

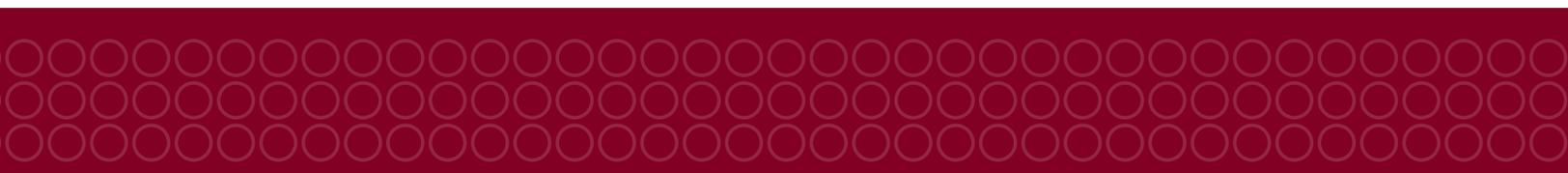


Pathways to Benefits

2011-2012 New Employee Guide



Ohio.gov | The State of Perfect Balance



Ohio The State of Perfect Balance



Welcome to the State of Ohio

Thank you for accepting the call to public service. Employment with the State of Ohio is more than just a job – it is a privilege to serve our families, friends and neighbors who rely on us throughout our great state. You are joining a team of diligent public servants dedicated to delivering excellent, efficient services. You will play a key role in our continued success.

The compensation you receive as a State of Ohio employee includes wellness and financial benefits explained in this guide.

The benefits outlined here are effective for this benefit year, which ends June 30, 2012.

THE JOINT HEALTH CARE COMMITTEE

JHCC Management Members:

- TONI BROKAW
Bureau of Workers Compensation
- MIKE D'ARCY
Department of Administrative Services
- AMY HAGER
Department of Developmental Disabilities
- DAVID LONG
Department of Administrative Services
- KEN KIRKSEY
Department of Health, Employee Assistance Program
- JIM KNIGHT
Department of Administrative Services
- KATE NICHOLSON
Co-Chair
Department of Administrative Services
- BARB PETERING
Department of Aging
- JAN ROEDERER
Rehabilitation Services Commission
- LAURA STEHURA
Department of Rehabilitation and Correction
- JUDY TSE
Department of Administrative Services

Members from OCSEA:

- CAROL BOWSHIER
Labor Co-Chair
- KATE CALLAHAN
State Board of Directors
Ohio Department of Transportation
- MAL COREY
Rehabilitation and Correction
- DEBRA KING-HUTCHINSON
State Board of Directors
Ohio Department of Jobs and Family Services
- LOUELLA JETER
State Board of Directors Public Safety
- LAWRENCE McKISSIC
Bureau of Workers Compensation

Members from the public employee unions:

- MARTY BARD
CWA
- JOEL BARDEN
FOP
- DOMINIC MARSANO
SCOPE/OEA
- BARBARA MONTGOMERY
SEIU 1199
- NIKKI SNEAD
Ohio State Troopers Association

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John R. Kasich,
Governor

Robert Blair,
Director

Ohio Department of
Administrative Services

Human Resources
Division

Benefits Administration
Services

das.ohio.gov/benefits



Benefits Enrollment Instructions

1. Review your benefits by carefully reading this New Employee edition of *Pathways to myBenefits*. If you have questions, contact your agency benefits representative (or human resources office) or HR Customer Service at 1.800.409.1205 or HRcustomerservice@das.state.oh.us.
2. Enroll in coverage through Self Service at: myOhio.gov or by using a paper Medical Benefit Enrollment and Change Form (ADM4717) available online at: das.ohio.gov/healthcareforms or from your agency benefits representative.

A. ONLINE – Go to: myOhio.gov to access Self Service for benefits.

- Enter your Employee ID number and password.
 - To obtain your Employee ID number or your password, contact HR Customer Service by e-mail at: HRcustomerservice@das.state.oh.us or call toll-free, 1.800.409.1205, or in Columbus, 614.466.8857.
- Click on Self Service.
- Click on **Benefits > Benefits Summary > Enroll in Benefits**.
- For detailed instructions on how to enroll or make changes online, go to: selfservice.ohio.gov.
- Availability

<u>Non-Payday Week</u>	
Monday – Thursday	All day except 7 to 9 p.m.
Friday	All day until 7 p.m. (ePay unavailable all day)
Saturday and Sunday	Unavailable
<u>Payday Week</u>	
Monday – Friday	All day except 7 to 9 p.m.
Saturday	All day except 4 to 6 p.m.
Sunday	Unavailable
- **Deadline** – Make and submit your selections through Self Service at: myOhio.gov within 31 days of your hire date. Make sure your online elections are correctly submitted. At the end of the process you will receive a confirmation message.

B. PAPER

- Obtain a paper Medical Benefit Enrollment and Change Form (ADM 4717) from your agency’s human resources office.
- **Deadline** – Give your completed and signed Medical Form to your agency’s human resources office within 31 days of your hire date.

IMPORTANT:

If you are enrolling your dependent(s) in your medical coverage, you are required to provide the required eligibility documentation for your dependents. A listing of the required documentation can be found at: das.ohio.gov/eligibilityrequirements.

Coverage will not be provided for dependents until the eligibility documents are received and approved by your agency human resources office.

It may take two to four weeks, from the completion of your enrollment process, to receive your medical identification card. To ensure timely processing of your enrollment, please complete your enrollment and provide all necessary dependent documentation as soon as possible.

If you have not already received your Employee ID in a letter or email, please contact your agency human resources office.

Benefits Eligibility

The State of Ohio provides quality, affordable and competitive benefits to permanent full-time and permanent part-time employees. Great care has been taken to select plan providers to ensure you receive quality benefits at a competitive rate.

Employee Eligibility

You are eligible for the state's benefits if you are a permanent full-time or permanent part-time employee, which includes established-term regular, established-term irregular, a judge or other elected or appointed official.

When will my coverage begin?

Commuter Choice Program (Qualified Transportation Benefit) – All State of Ohio employees who authorize a payroll deduction by the fifth day of each month are eligible.

Dependent Care Spending Account (Flexible Spending Account) – Permanent employees are eligible the first day of the month following their date of hire.

Health Care Spending Account (Flexible Spending Account) – Permanent employees are eligible the first day of the month following completion of their probationary period.

Medical – Most state employees are eligible for medical coverage (including prescription drug, *Take Charge! Live Well!* (TCLW) and behavioral health) effective the first day of the month following the month of their date of hire.

Long Term Care – You may be eligible for long-term care benefits if you are between the ages of 18 and 84, either a permanent full-time employee or permanent part-time employee, working 20 hours or more per week and who is actively at work. New employees who meet the eligibility requirements can enroll without proof of good health within 31 days of their hire date.

If you are eligible for long term-care, your spouse, parents, parents-in-law, grandparents and grandparents-in-law, sibling

and adult children also are eligible. However, proof of good health will be required. These eligible individuals may enroll for long-term care even if you do not.

Supplemental Life – Exempt and union-represented employees are eligible for supplemental life insurance coverage on their date of hire and have 90 days to enroll. You must enroll directly with the carrier.

Basic Life – Exempt and union-represented employees are eligible for basic life insurance coverage after completing one full year of continuous state service. Enrollment is automatic.

Dental and Vision – Exempt and union-represented employees are eligible for dental and vision coverage effective the first day of the month after completing one full year of continuous state service.

Disability – Full-time permanent employees who have completed one year of continuous state service and part-time permanent employees who have completed one year of continuous state service and who have worked 1,500 or more hours within the 12 calendar months preceding disability may be entitled to disability benefits.



Bargaining unit employees receive certain benefits through Benefits Trust including dental, vision, basic life and supplemental life insurance, Working Solutions, as well as the legal service plan. For more information on these benefits, visit: benefitstrust.org/home.htm.

Dependent Eligibility

Family members as described below may be eligible for coverage under your health and wellness benefits package. Documentation will be required at the time of dependent enrollment to verify eligibility. To view the detailed eligibility and documentation requirements for all dependents, please go to das.ohio.gov/eligibilityrequirements.

1. Spouse

- Your current legal spouse as recognized by Ohio law.

2. Children younger than age 26 including:

- Your biological children (married or unmarried)
- Your legally adopted children: adopted children have the same coverage as children born to you or your spouse, whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption.
- Your dependent stepchildren
- Non-emancipated foster children
- Children for whom either you or your spouse has been appointed legal guardian

- Children for whom the plan has received a Qualified Medical Child Support order: the child must be named as your alternate recipient in the order.

Note: Dependent children are only eligible for dental/vision benefits if unmarried and younger than age 23. Dependent children ages 19-22 with dental/vision coverage must be students.

3. Unmarried Children Incapable of Self-Care

Unmarried children who are incapable of self-support due to mental retardation, severe mental illness or physical handicap, whose disability began before age 26 and who are primarily dependent upon you are eligible for medical coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled for coverage, provided that the application is submitted within five years following loss of coverage.

CONTINUED ON PAGE 6 ►



This coverage is not automatic. You must complete the applicable form for your Third-Party Administrator (TPA). A form for each TPA can be found at: das.ohio.gov/healthplanforms.

Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

HB1 Child

Ohio House Bill 1 of the 128th General Assembly created a new category of eligibility for the state medical plan. HB1 coverage is available for medical (including prescription drug and behavioral health) coverage only.

HB1 Child requirements:

- Your unmarried child, age 26 or 27; and
- Child is your natural child, stepchild or adopted child; and
- Child is a resident of Ohio or a full-time student at an accredited public or private institution of higher education; and
- Child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and
- Child is not eligible for state Medicaid or federal Medicare.

A special rate applies for these children.

You can enroll your HB1 child with the annual Affidavit of House Bill 1 Child

When you enroll your HB1 Child, you must indicate on the applicable form whether the child qualifies as an IRS tax dependent or a child (within the meaning of 26 USC 152(f) (1)) who has not attained age 27 as of the end of the taxable year. You may wish to consult with an independent tax advisor as to your HB1 child’s status under the Internal Revenue Code and IRS regulations. If your HB1 child qualifies as an IRS tax dependent or as a child (within the meaning of 26 USC 152(f) (1)) who has not attained age 27 as of the end of the taxable year, the deduction for coverage will occur before adjusted gross income is calculated (pre-tax dollars). If your HB1 child does not meet one of these qualifications, the deduction for coverage will occur after adjusted gross income is calculated.



DEPENDENT CATEGORY	MEDICAL	DENTAL	VISION	SUPPLEMENTAL LIFE
Children younger than age 23	Coverage available for eligible dependents ¹	Coverage available for eligible dependents ¹	Coverage available for eligible dependents ¹	Coverage available for eligible dependents ²
Children ages 23 - 25	Coverage available for eligible dependents ¹	No coverage available	No coverage available	No coverage available
Children ages 26 - 27	Coverage available for eligible HB1 dependents ¹	No coverage available	No coverage available	No coverage available

¹View detailed eligibility and documentation requirements at: das.ohio.gov/eligibilityrequirements.

²View eligibility requirements on Prudential enrollment form.

Note: When one of your enrolled dependents is or becomes ineligible for benefits coverage based on the state’s definition of eligibility, it is your responsibility to contact your agency benefits specialist (or human resources office) immediately to remove them from your coverage. Your dependent may be eligible to continue their medical, dental and/or vision benefits through the federal COBRA Act if you notify your agency benefits specialist (or human resources office) within 60 days after the qualifying event occurs. Enrollment or continuation of an ineligible dependent may result in loss of benefits, disciplinary action and/or repayment of claims.



An employee may enroll or disenroll an HB1 Child during the annual open enrollment period, when the child reaches the plan's limiting age, or when a child experiences a change in circumstances. Examples of a change in circumstance (Ohio Administrative Code 3901-8-13) include moving back to Ohio or the child's loss of employer-sponsored coverage.

Examples of persons NOT eligible for coverage as a dependent include, but are not limited to:

- A spouse from whom the employee is legally divorced or legally separated
- Children who are age 26 (HB1 Child coverage may be available)
- A spouse or child currently in the military service, eligible for coverage under a federal health plan
- Same-sex partners
- Live-in boyfriends or girlfriends
- Parents or parents-in-law
- Grandchildren (unless employee is the court-appointed legal guardian)
- Adults who are not the employee's or spouse's child under guardianship of employee (brother, sister, aunt, uncle, etc.)
- A spouse from a common law marriage established after October 10, 1991
- Any other members of your household who do not meet the definition of an eligible dependent

Employees are required to disenroll a dependent who may become ineligible for coverage at a future date. Visit the Definitions and Required Documents Checklist at das.ohio.gov/eligibilityrequirements to learn what is needed to disenroll an ineligible dependent.

Providing false or misleading dependent eligibility information may result in any or all of the following actions by the State of Ohio: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible dependents; and/or 4) civil and/or criminal prosecution.



Medical



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IN
the
KNOW

Medical Mutual
1.800.822.1152
medmutualstateohioemployee.com

UnitedHealthcare
1.877.440.5977 / *myuhc.com*

Prescription Drug
Catalyst Rx
1.866.854.8850 / *catalystrx.com*

**Behavioral Health
and Substance Abuse**
United Behavioral Health
1.800.852.1091 / *liveandworkwell.com*

Take Charge! Live Well!
APS Healthcare
1.866.272.5507
stateofohio.apshealthcare.com

Delta Dental of Ohio
1.800.524.0149 exempt
1.877.334.5008 union-represented
deltadentaloh.com

EyeMed Vision Care
1.866.723.0514 / *eyemedvisioncare.com*

Vision Service Plan (VSP)
1.800.877.7195 / *vsp.com*

Your Medical Coverage

When you enroll in medical coverage, you automatically gain prescription drug, behavioral health and *Take Charge! Live Well!* benefits.

State of Ohio employee health plans do not contain pre-existing condition exclusions; therefore, coverage is available to you and your eligible dependents regardless of current health or health history.

Medical coverage begins on the first day of the month following the month of your date of hire. The cost of this coverage is shared between the employee and your agency. You can enroll online using eBenefits. To access Self Service instructions, refer to the Benefits Enrollment Instructions on Page 2. You also can submit a completed Medical Benefit Enrollment and Change Form (ADM 4717) to your agency human

3-DIGIT ZIP CODE BREAKDOWN							
UNITEDHEALTHCARE (UHC)							
430xx	431xx	432xx	433xx	437xx	438xx	439xx	444xx
445xx	450xx	451xx	452xx	453xx	454xx	455xx	459xx
MEDICAL MUTUAL							
434xx	435xx	436xx	440xx	441xx	442xx	443xx	
446xx	447xx	448xx	449xx	456xx	457xx	458xx	

resources representative. You must complete your enrollment within 31 days of your date of hire along with required documentation. The form is available online at: das.ohio.gov/healthcareforms.

If you do not enroll within this time frame, you must wait until the annual open enrollment period or until you experience a qualifying event. A listing of qualifying events is available online at: das.ohio.gov/qualifyingevents.

Visit the Definitions and Required Documents Checklist at: das.ohio.gov/EligibilityRequirements to learn what is needed to enroll an eligible dependent. Benefits and rate information are located on Pages 10 through 12.

The state has contracted with Medical Mutual and UnitedHealthcare (UHC) to serve as the third-party administrators for the Ohio Med PPO plan. This plan will allow all employees to have access to both network and non-network providers.

Medical Mutual and UHC will each serve a specific region in Ohio based upon home ZIP codes. The administrator you will be assigned is based on the first three digits of your home ZIP code. Please review the ZIP Code Breakdown chart by plan administrator. Employees with home ZIP codes outside Ohio will be enrolled in UHC.

All employees must have a valid home address on file with the State of Ohio. While an employee may continue to list a P.O. box as a mailing address, an employee may not use a P.O. box as a home address.



FULL-TIME EMPLOYEE MEDICAL DEDUCTIONS

	FULL-TIME / BIWEEKLY-PAID EMPLOYEE DEDUCTIONS ²			FULL-TIME / MONTHLY-PAID EMPLOYEE DEDUCTIONS ²		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	\$31.20	\$175.76	\$206.96	\$70.20	\$395.45	\$465.65
Family Minus Spouse	\$85.41	\$482.95	\$568.36	\$192.17	\$1,086.63	\$1,278.80
Family Plus Spouse ¹	\$90.97	\$482.95	\$573.92	\$204.67	\$1,086.63	\$1,291.30

¹ Family Plus Spouse rates above include a charge of \$12.50 per month to cover a spouse.

² These rates represent the total amount that will be deducted from your paycheck, including the communication surcharge.

PART-TIME EMPLOYEE MEDICAL DEDUCTIONS

	PART-TIME BIWEEKLY DEDUCTIONS ² 75% TIER			PART-TIME BIWEEKLY DEDUCTIONS ² 50% TIER		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	\$51.85	\$155.11	\$206.96	\$103.48	\$103.48	\$206.96
Family Minus Spouse	\$142.20	\$426.16	\$568.36	\$284.18	\$284.18	\$568.36
Family Plus Spouse ¹	\$147.76	\$426.16	\$573.92	\$289.74	\$284.18	\$573.92

	PART-TIME BIWEEKLY DEDUCTIONS ² 0% TIER		
	Employee Share	State Share	Total
Single	\$206.96	\$0.00	\$206.96
Family Minus Spouse	\$568.36	\$0.00	\$568.36
Family Plus Spouse ¹	\$573.92	\$0.00	\$573.92

ADDITIONAL RATES FOR EACH HB1 DEPENDENT (FOR ALL ENROLLED EMPLOYEES)

Biweekly Deduction Amount: \$85.43

Monthly Deduction Amount: \$192.22

¹ Family Plus Spouse rates above include a charge of \$12.50 per month to cover a spouse.

² These rates represent the total amount that will be deducted from your paycheck, including the communication surcharge.



OHIO MED PPO	
OUT-OF-POCKET COSTS	
Annual Deductible	Network: \$200 single, \$400 family; out of network: \$400 single, \$800 family.
Your Copayments (Office Visits)	Network: \$20; out of network: \$30.
Coinsurance	Network: You pay 20%, plan pays 80%; out of network: You pay 40%, plan pays 60%. ¹
Your Out-of-Pocket Maximum	Network: \$1,500 single, \$3,000 family; out of network: \$3,000 single, \$6,000 family. ²
BENEFIT/SERVICE	COVERAGE LEVELS
Chiropractic Care	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network. Unlimited visits.
Diagnostic, X-Ray and Lab Services	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Durable Medical Equipment	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Emergency Room	<ul style="list-style-type: none"> Covered at 80%; \$75 copay, which is waived if patient is admitted; 60% out of network for non-emergency.
Hearing Loss (Accidental, Injury or Illness)	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network. Exams and follow-ups are included in coverage. No lifetime maximum.
Home Health Care	<ul style="list-style-type: none"> Covered at 80% network; 60% out of network; limit of 100 visits or 180 days.
Hospice Services	<ul style="list-style-type: none"> Covered at 100% with no copay, time or dollar limitations. For both in and out of network.
Immunizations	<ul style="list-style-type: none"> Most are covered at 100% (see Page 9). For both in and out of network.
Infertility Testing	<ul style="list-style-type: none"> Covered at 80% after \$20 copay, for in network; 60% and \$30 copay out of network. Coverage includes testing only.
Inpatient and Outpatient Services	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Maternity - Delivery	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Maternity - Prenatal Care	<ul style="list-style-type: none"> Office visits covered at 100% when billed separately from delivery; tests/procedures covered at 80% in network; 60% out of network.
Physical, Occupational and Speech Therapy	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network. Unlimited visits.
Preventive Exams & Screenings	<ul style="list-style-type: none"> Most preventive care covered at 100% (see Preventive Care chart on Page 9). Age restrictions may apply.
Skilled Nursing Facility	<ul style="list-style-type: none"> Covered at 80%; 180-day limit, additional days covered at 60%, for both in and out of network.
Urgent Care	<ul style="list-style-type: none"> \$25 copay in network; \$30 copay out of network. Covered at 80% in network; 60% out of network.

¹ Plan pays 60% of Ohio Med's benefit allowance and you pay any remaining balance.

² If your non-network provider charge is greater than the Ohio Med PPO allowance, your out-of-pocket costs will be more.

Preventive Care Screening – Stay Healthy, Save Money

Preventing and detecting disease early is important to living a healthy life. The better your health, the lower your health care costs are likely to be. One of the most important actions you can take for your health and your family's health is to schedule regular check-ups and screenings with your primary care physician (PCP).

Your State of Ohio health plan – Ohio Med PPO – offers the following services with no deductible, no copayment and no coinsurance. Other services are available for the normal copayment, coinsurance and deductible amounts.

FREE EXAMS AND SCREENINGS		FREE IMMUNIZATIONS	
Clinical breast exam	1/plan year	Diphtheria, tetanus, pertussis (DTap)	2/4/6/15-18 months; 4-6 years
Colonoscopy	Every 10 years starting at age 50	Haemophilus influenza b (Hib)	2/4/6/12-15 months
Flexible sigmoidoscopy	Every 10 years starting at age 50	Hepatitis A (HepA)	2 doses between 1-2 years
Glucose	1/plan year	Hepatitis B (HepB)	Birth; 1-2 months; 6-18 months
Gynecological Exam	1/plan year	Human Papillomavirus (HPV)	3 doses for females age 9 through 26 years
Hemoglobin, hematocrit, or CBC	1/plan year	Influenza	1/plan year
Lipid profile or total and HDL cholesterol	1/plan year	Measles, mumps, rubella (MMR)	12-15 months, then at 4-6 years; adults who lack immunity
Mammogram	1 routine and 1 medically necessary/plan year	Meningococcal (MCV4)	1 dose between 11-12 years or start of high school or college
Pre-natal office visits	As needed; based on physician's ability to code claims separately from other maternity-related services	Pneumococcal	2/4/6 months; 12-15 months; annually at age 65 and older; high risk groups
PSA	1/plan year starting at age 40	Poliovirus (IPEV)	2 and 4 months; 6-18 months; 4-6 years
Stool for occult blood	1/plan year	Rotavirus (Rota)	2/4/6 months
Urinalysis	1/plan year	Tetanus, diphtheria, pertussis (Td/Tdap)	11-12 years; Td booster every 10 years, 18 and older
Well-baby, well-child exam	Various for birth to 2 years; then annual to age 21	Varicella (Chickenpox)	12-15 months; 4-6 years; 2 doses for adult susceptible
Well-person exam (annual physical)	1/plan year	Zoster (shingles)	1 dose for age 19 +

Note: This is not an all-inclusive list. Please refer to: healthcare.gov/law/about/provisions/services/lists.html for an exhaustive list of covered preventive care services.

To ensure all state employees receive the highest level of care and customer service, a single prescription drug vendor, Catalyst Rx, provides prescription drug benefits for all State of Ohio employees who are enrolled in the Ohio Med PPO plan.

Employees receive a Catalyst Rx identification card, which must be presented at the pharmacy when filling prescriptions. You will not be able to purchase medications with your health plan ID card. For a listing of what's covered under your prescription drug benefits, go to: www.catalystrx.com, and click on "covered drug list" in the main menu. You also may look for individual drug names in the "drug dictionary."

SAVE MONEY – USE THE 90-DAY MAIL-ORDER PROGRAM

Using mail order for your ongoing maintenance medications is convenient and cost effective. Ordering your prescription medications through the Immediate Pharmaceutical Services (IPS) mail-order pharmacy will save you money on your copayments.

90-DAY AT RETAIL PROGRAM

If you do not want to use the mail-order program, you can receive a 90-day supply of medication at your local retail pharmacy.

PREVENTIVE MEDICATIONS COVERED AT NO CHARGE WITH A PRESCRIPTION EFFECTIVE JULY 1, 2011*

Federal health care reform requires that certain preventive medications and treatments be covered at no charge effective July 1. These include:

- Generic aspirin to prevent heart disease for men and women age 45 or older; 1 per day; generic only; requires prescription.
- Fluoride solution or tablets for children younger than the age of 5. Prescription products only.
- Over-the-counter folic acid supplements for women age 55 or younger; 1 per day; requires prescription.
- Iron supplements for children up to 12 months old; requires prescription.

*You must present your Catalyst Rx card to take advantage of these no-cost medications.

Your Prescription Drug Benefits

Type of Medication	30-Day supply at Retail Copayment	90-Day supply at Retail Copayment	90-Day supply at Mail Service Copayment
Generic	\$10	\$30	\$25
Preferred Brand-Name	\$25	\$75	\$62.50
Non-Preferred Brand-Name, Generic Unavailable	\$50	\$150	\$125
Non-Preferred Brand-Name, Generic Available	\$50 plus the difference between the cost of the brand-name and generic drug	\$150 plus the difference between the cost of the brand-name and generic drug	\$125 plus the difference between the cost of the brand-name and generic drug

The amount charged to the individual for generic, preferred brand and non-preferred brand medications will not be greater than the actual cost of the medication. Therefore, the amount charged may be less than the flat-dollar copay.

Pharmacy copays do not apply toward medical plan deductibles and the annual out-of-pocket maximum.

SPECIALTY DRUG MANAGEMENT PROGRAM

Some specialized medications for serious medical conditions such as cancer, cystic fibrosis and rheumatoid arthritis must be obtained from Walgreens Specialty Pharmacy after your first fill. Your order may be shipped to your home, workplace or a local Walgreens for pickup. A description of the program and a list of specialty medications may be found on the Benefits Administration website at: das.ohio.gov/prescriptiondrug under "Important Prescription Drug Updates."

NOT ALL DRUGS ARE COVERED

Some drugs require the use of alternative medications before being approved. This is known as "step therapy." Examples include heartburn medications, drugs used for migraines, osteoporosis, nasal allergies, sleep disturbances, high blood pressure, atypical antipsychotics and antiviral

medications such as Valtrex®. Additional medications requiring step therapy may be added at any time. If this occurs, members currently using the affected drugs will be notified by mail. A description of the program and a list of medications are on the Benefits Administration website at: das.ohio.gov/prescriptiondrug under "Important Prescription Drug Updates."

Nutritional supplements and specialized baby formulas are not a covered benefit.

Behavioral Health Benefits

Specialized mental health and chemical dependency services are provided under a single program available to all employees and dependents enrolled in the state's Ohio Med PPO plan. This program, administered by United Behavioral Health (UBH) and also known as OptumHealth Behavioral Solutions, provides 24-hours-a-day, seven-days-a-week telephonic assessment and referral services for a variety of behavioral health issues, such as:

- Depression
- Stress
- Serious mental illnesses
- Marital and family issues
- Alcohol and drug dependency
- Anxiety

The program includes a disability component in which employees who require time off for behavioral health conditions have access to specialized providers on an expedited basis.

OUT-OF-NETWORK BENEFITS

All enrolled employees and their families, will have out-of-network behavioral health benefits. This means that you may seek treatment from any behavioral health provider that you wish; however, you will pay more if you do not use UBH participating providers and facilities.

Your out-of-network office visit copayment will be \$30 instead of \$20 and your provider may balance bill you for the difference between their charge and what UBH allows.

Inpatient services will be paid at 60 percent of the UBH allowed amount instead of 80 percent and you may be balance billed for the difference between the facility charge and what UBH allows.

Copayments, deductibles and coinsurance must be shared and combined with your medical plan pursuant to federal mental health parity requirements. If you receive mental health services prior to meeting your medical plan deductible, you may need to pay for these services up to the deductible amount before your plan starts paying. This does not apply to routine office visits for which you only pay an office visit copayment.

BEHAVIORAL HEALTH BENEFIT PLAN DESIGN	
Copayments	
Outpatient in-network	\$20
Outpatient out-of-network	\$30
Emergency Room	\$75
Intensive outpatient care in-network	\$20
Intensive outpatient care out-of-network	\$30. Balance billing applies
Deductibles	
Single in-network	\$200 combined with medical
Family in-network	\$400 combined with medical
Single out-of-network	\$400 combined with medical
Family out-of-network	\$800 combined with medical
Plan coinsurance %	
Outpatient in-network	100% after office visit copay: 80% for some services
Outpatient out-of-network	60% of fee schedule after copayment. Balance billing applies.
Inpatient in-network	80% after deductible. \$350 penalty if not preauthorized.
Inpatient out-of-network	60% after deductible. \$350 penalty if not preauthorized.
Out-Of-Pocket Maximum	
Single in-network	\$1,500 combined with medical
Family in-network	\$3,000 combined with medical
Single out-of-network	\$3,000 combined with medical
Family out-of-network	\$6,000 combined with medical
Other	
Day Limits	None
Annual Limits	None
Lifetime Limits	None
Benefits Limits	Some

Take Charge! Live Well!

Employees have the potential to earn rewards for taking actions to improve their health.

Taking responsibility for your health and staying healthy is the best strategy for keeping health care costs at a reasonable level.

The *Take Charge! Live Well!* program is administered by APS Healthcare. For more information or to speak with a health coach, visit the program website at: ohio.gov/tchv or call 1.866.272.5507.

HEALTH ASSESSMENT – EARN \$25

Complete the 15-minute health risk questionnaire at: ohio.gov/tchv by Nov. 30, 2011, and earn \$25. You will receive a customized report based on your responses.

BIOMETRIC SCREENING – EARN UP TO \$75

What is a biometric screening?

A biometric screening is a quick blood test that checks your total cholesterol, HDL level, blood glucose level, blood pressure and body mass index (BMI). These results can give you and your doctor a snapshot of your health and identify any health risks.

You can complete a biometric screening in two ways: you can get a screening from your doctor during an annual physical or at a worksite *Take Charge! Live Well!* road show.

In order to complete the biometric screening through your doctor's office, please go to: ohio.gov/tchv and print the Biometrics Physician Form. Give your doctor the form at your next physical exam and ask them to complete it with your test results.

We also offer several worksite screenings each year throughout the state. For a list of worksite screenings close to you, please visit the worksite event calendar on the *Take Charge! Live Well!* website at: ohio.gov/tchv for dates.

If you and/or your spouse qualifies, you can each earn up to an additional \$100 for participation in one of the targeted health coaching programs.

To get started, contact APS Healthcare at 1.866.272.5507 to sign up.

What should I expect?

Your first call with a health coach will take approximately 30 minutes. The health coach will give you a brief overview of the program, followed by a general assessment and education, and then you and your coach will set goals. After you complete the initial health coaching call, you will earn a \$25 incentive.

If you complete three additional calls with a health coach (approximately 20 minutes each), you can earn another \$75.



Everyone can earn \$100

Health Assessment	Completed by Nov. 30, 2011	\$25
Biometric Screening	Completed by June 30, 2012	\$75

Complete a health assessment or biometric screening and earn an additional \$100 when identified for one of the following programs:

	1st Coaching Call	4th Coaching Call completed by June 30, 2012
Tobacco Cessation*	\$25	\$75
Weight Management*	\$25	\$75
Disease Management*	\$25	\$75

*APS Healthcare will identify eligible employees and spouses based on biometric screening results, claims experience or health assessment results for these programs. For questions on whether you qualify, contact APS Healthcare at 1.866.272.5507.



WEIGHT MANAGEMENT COACHING – EARN UP TO \$100

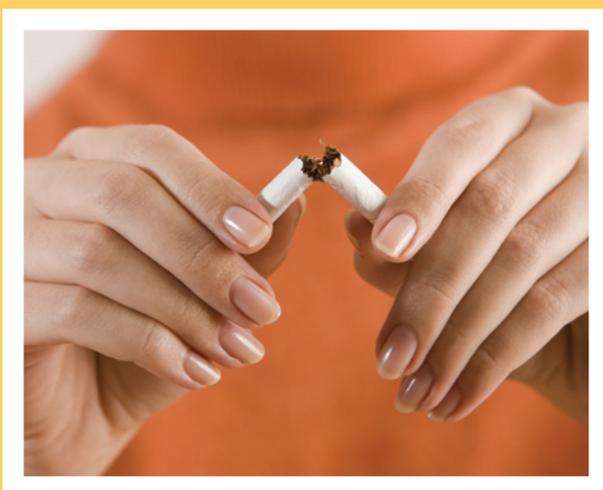
If you or your spouse’s biometric screening or health care claims indicate that you have a Body Mass Index (BMI) of 30 or more, you are eligible to participate in weight management coaching.

What is BMI? It is a calculation based on your height and weight that can indicate your health risk. Research consistently shows that overweight people are at greater risk for several diseases. Use this program to get started!

TOBACCO CESSATION COACHING – EARN UP TO \$100

If you or your spouse use tobacco and are ready to work on quitting, you can earn up to \$100 for working with a health coach. Use of nicotine replacement therapy or prescription drugs along with counseling can significantly increase your chances of quitting. For additional information on covered nicotine pharmaceuticals, please visit: ohio.gov/tclw.

Participants in tobacco cessation coaching will be eligible for free nicotine pharmaceuticals.



DISEASE MANAGEMENT COACHING – EARN UP TO \$100

If you have been diagnosed with diabetes, congestive heart failure, coronary artery disease, asthma or chronic obstructive pulmonary disease, you are eligible to participate in a disease management program.

What is disease management?

Whether you are newly diagnosed or have lived with a condition for years, this program can help empower you to take charge of your health. Registered nurses can help you better understand your condition, understand medications and treatments that you have been prescribed and help you with any additional conditions you may have.

Employees working with an APS Healthcare health coach, are eligible to receive free diabetic medications and supplies. Contact APS Healthcare at 1.866.272.5507 for additional information.

Exempt Dental and Vision Benefits

The state pays the full cost for you and your eligible dependents (children younger than age 23) to participate in the dental and vision plans. The state also pays the full cost for you to participate in the basic life plan. Employees are eligible to participate in these programs after one year of continuous state service.

An enrollment packet will be mailed to you prior to your one year anniversary. Coverage will be effective the first day of your 13th month of state service, as long as you have completed an enrollment form at least 31 days before your anniversary date. You may enroll in dental and vision coverage up to 31 days after your anniversary date, but your effective date of benefits may be delayed. If you do not enroll within 31 days of your anniversary date, you must wait until the next open enrollment period to obtain dental and/or vision care coverage.

EXEMPT DENTAL PLAN

If you are an exempt employee, regardless of where you live, you can choose to participate in either the Delta Dental PPO or the Delta Dental Premier plan offered through Delta Dental of Ohio. When you participate in either of the dental plans, you can go to the dentist of your choice and receive benefits. However, you will generally pay less when you go to a dentist who belongs to the Delta Dental PPO or Delta Dental Premier network. When making your coverage selection, be sure to check with your dentist to determine whether he/she belongs to the network.

Print Your Delta Dental Card Online

Upon enrollment in a dental plan, you are not provided with a Delta Dental card. However, if you would like a card to present to your dentist, you may obtain one through Delta Dental's website. Once you have enrolled in a dental plan, visit: deltadentaloh.com and click on "Consumer Toolkit." Complete the login process and click on "Print ID Card."



EXEMPT VISION PLAN

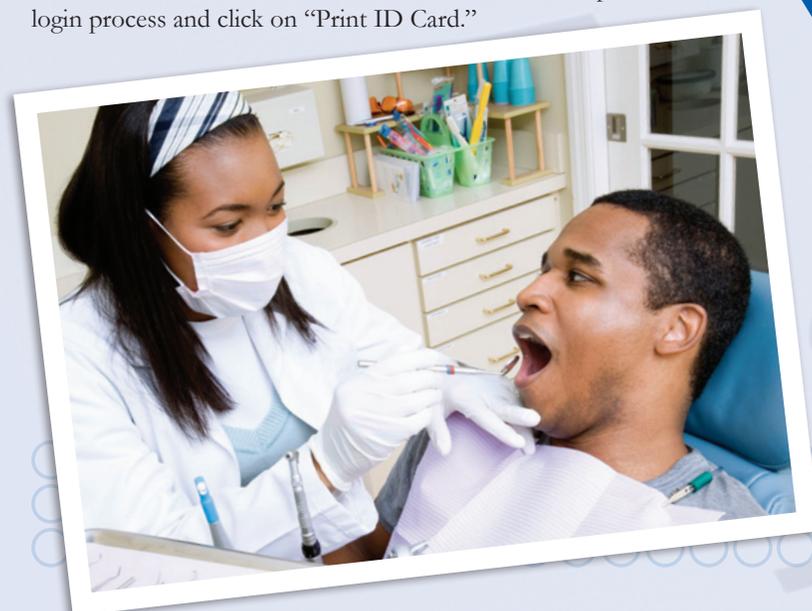
Eligible exempt employees have the option of enrolling in the Vision Service Plan (VSP) or the EyeMed Vision Care plan.

Did you know?

A primary difference between vision plans is the provider network. Be sure to check with your vision provider to determine whether your provider belongs to the VSP Signature network or EyeMed Vision Care's Select network. Check with each plan for a complete provider list.

UNION-REPRESENTED EMPLOYEES

Bargaining unit employees receive certain benefits through Benefits Trust including dental, vision, basic life and supplemental life insurance, Working Solutions, as well as the legal service plan. For more information on these benefits, visit benefitstrust.org/home.htm.



EXEMPT DENTAL PLAN

PLAN 1: DELTA DENTAL PPO			PLAN 2: DELTA DENTAL PREMIER		
	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Delta Dental Dentist	Delta Dental Premier Dentist	Non-Delta Dental Dentist
Annual Maximum	\$1,500	\$1,000	\$1,000*	\$1,500	\$1,500*
Class 1: Diagnostic & Preventive Services	100%	100%	100%*	100%	100%*
Class 2: Basic Restorative Services (e.g., fillings)	100%	65%	65%*	65%	65%*
Class 3: Major Restorative Services (e.g., crowns; bridges)	60%	50%	50%*	50%	50%*
Class 4: Orthodontia	50% up to \$1,500 Lifetime maximum	50% up to \$1,500 Lifetime maximum	50%* up to \$1,500 Lifetime maximum	50% up to \$1,500 Lifetime maximum	50%* up to \$1,500 Lifetime maximum

There is a separate \$1,000 lifetime maximum on dental implants available in both plans.

*Delta Dental will pay up to the allowed amount or the maximum allowable charge for providers in your area. You can be balance billed by non-Delta Dental providers for any amount that exceeds the allowable amount. Network providers cannot balance bill you for the difference between their charge and Delta Dental's allowed amount.

EXEMPT VISION PLAN

VISION SERVICE PLAN (VSP)		EYEMED PLAN		
Service	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Network	VSP Signature		Select	
Routine Exam/Frame/ Lens Frequency	1 every 12 months		1 every 12 months	
Routine Exam/ Professional Fees	Plan pays 100% after \$10 copay.	You pay \$10 copay, then plan pays maximum of \$25.	Plan pays 100% after \$5 copay.	The plan reimburses a maximum of \$25.
MATERIALS/LENSES		You pay \$15 copay, then plan pays maximum benefit of:		Plan reimburses a maximum benefit of:
Single Vision Lenses	Plan pays 100% after \$15 copay.	\$25	Plan pays 100%.	\$25
Bifocal Lenses		\$35		\$35
Progressive Lenses		\$52		\$55
Trifocal Lenses		\$52		\$52
Lenticular Lenses		\$62		\$62
Polycarbonate Lenses (Available to All)		\$0		\$0
FRAMES	Plan pays 100% up to \$120 retail.	Plan pays maximum benefit of \$18.	Plan pays 100% up to \$120 retail.	Plan reimburses a maximum benefit of \$18.
CONTACT LENSES				
Elective (Instead of Lenses & Frames)	Plan pays maximum of \$125 plus standard eye exam.	Plan pays maximum of \$125 plus standard eye exam.	Plan pays maximum of \$125 plus standard eye exam.	Plan reimburses a maximum of \$105 plus standard eye exam.
Medically Necessary	Plan pays 100% plus standard eye exam.	Plan pays maximum of \$125 plus standard eye exam.	Plan pays 100% plus standard eye exam.	Plan reimburses a maximum of \$105 plus standard eye exam.

Financial Security



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IN the KNOW

Basic Life Insurance
The Standard
1.866.415.9518
standard.com/mybenefits/ohio

Long Term Care Insurance
(Exempt and Union-represented)
Prudential Long Term Care Solid Solutions
1.800.732.0416
Prudential.com/GLTCWEB

Supplemental Life Insurance
Prudential Life Insurance
1.800.778.3827

Financial Security

Forecasting future financial needs can be challenging. Whether you are attempting to assess retirement goals or ensure that your family is provided for in the event that the unanticipated happens, we understand your financial security is an especially important concern. The retirement plans and insurance programs available through the State of Ohio offer steady sources of income and can be tailored to your specific needs.

All policy benefits are subject to limitations and restrictions. Visit das.ohio.gov/benefits for more information about:

- Basic Life Insurance
- Supplemental Life Insurance
- Disability Insurance
- Workers' Compensation
- Long Term Care

 **Union-represented employees may visit:** benefitstrust.org or see **Page 36** for basic and supplemental life insurance contact information.

EXEMPT BASIC LIFE INSURANCE (Through The Standard)

The State of Ohio provides basic life insurance, including an accidental death and dismemberment benefit for work-related injuries, free of charge to all eligible exempt employees who have one year of continuous state service. This benefit is equal to one times your annual salary rounded to the nearest \$1,000, is provided at no cost to you, and enrollment is automatic.

The IRS requires that employees be taxed on the value of employer-paid group life insurance coverage exceeding \$50,000. This is known as “imputed income.” If your annual rate (and thus your group life insurance) exceeds \$50,000 per year, the tax you owe on the value of the coverage that exceeds \$50,000 is reported to the IRS in Box 12 of your year-end W-2 form. The tax is based upon employee age brackets on the last day of the calendar year and increases in five-year increments as you grow older. See page 21 for the imputed income rate table.

EXEMPT SUPPLEMENTAL LIFE INSURANCE (Through Prudential)

Exempt employees are eligible for supplemental life insurance coverage. When you enroll in supplemental life insurance coverage, you also may elect life insurance for your eligible dependents. The amount you contribute toward your supplemental and dependent life coverage is deducted from your paycheck.

For Yourself

You may enroll for Supplemental Life Insurance Coverage on your date of hire and you have 90 days to enroll. You can enroll up to six times your Basic Annual Earnings, rounded to the next higher \$10,000, not to exceed \$500,000. You must provide evidence of insurability (EOI) if you request an amount of insurance over the Non-medical Limit for new hires - the lesser of three times your basic annual earnings or \$150K. Coverage below the Non-medical Limit amount will be effective the first of the month after your first supplemental life payroll deduction. Coverage above the Non-medical amount, which is subject to EOI, will be effective first of the month after your EOI has been approved.

For Your Spouse

You can purchase supplemental life insurance for your spouse in \$10,000 increments up to \$40,000. Spousal coverage in excess of \$10,000 requires your spouse to provide proof of good health.

For Your Dependent Children

You may purchase \$7,000 of life coverage for each of your eligible dependent children younger than age 23 at a rate of \$0.99 cents per month regardless of how many children you cover. You are responsible for dropping your dependent's coverage when your child reaches age 23.

How to Enroll in Supplemental Life

Exempt employees will need to enroll with Prudential. You may also obtain a supplemental life enrollment form on the Benefits website Forms page at: das.ohio.gov/healthplanforms.

Should you have questions regarding supplemental life insurance, please contact Prudential. You may be asked to provide the group number for State of Ohio exempt employees. The group number is: LG-93046-OH. See the Contacts section of this publication for more information.

BENEFICIARY FORMS (Exempt Basic and Supplemental Life Insurance)

Beneficiary forms for The Standard and Prudential are available in the forms section of the Benefits Administration website at: das.ohio.gov/healthplanforms.


IRS BASIC LIFE IMPUTED INCOME CHART
 (Monthly Cost Per \$1,000 of Coverage in Excess of \$50,000)

AGE	COSTS
Younger than 25	\$0.05
25 through 29	\$0.06
30 through 34	\$0.08
35 through 39	\$0.09
40 through 44	\$0.10
45 through 49	\$0.15
50 through 54	\$0.23
55 through 59	\$0.43
60 through 64	\$0.66
65 through 69	\$1.27
70 and older	\$2.06

EXEMPT SUPPLEMENTAL LIFE INSURANCE RATE CHART
 (Monthly Cost per \$10,000 of Coverage)

AGE AS OF JULY 1, 2011	NON-SMOKER	SMOKER
29 and Younger	\$0.59	\$0.78
30 through 34	\$0.72	\$0.78
35 through 39	\$0.82	\$1.14
40 through 44	\$1.30	\$1.76
45 through 49	\$2.01	\$2.92
50 through 54	\$3.13	\$4.50
55 through 59	\$5.02	\$6.69
60 through 64	\$7.61	\$10.26
65 through 69	\$12.36	\$18.41
70 and Older	\$20.94	\$32.95



DISABILITY BENEFITS

As a State of Ohio employee, you are eligible to apply for disability leave benefits. These medical benefits provide financial and emotional assistance to you and your family in the event that you are unable to perform the duties of your position due to a non-work-related disabling illness, injury or condition for a period of more than 14* consecutive calendar days.

*Contract exceptions for length of waiting period - Attorney General, FOP 46 and FOP 48 - please refer to your contract.

Disability Eligibility

To be eligible for disability benefits, all of the following must apply:

- Any full-time permanent employee with a disabling illness, injury, or condition that will last more than 14 consecutive calendar days and who has completed one year of continuous state service immediately prior to the date of the disability may be eligible for disability leave benefits.
- Part-time employees who have completed one year of continuous state service and who have worked 1,500 or more hours within the 12 calendar months preceding disability may be entitled to disability benefits.

What conditions are covered?

The following disabling illnesses, injuries or conditions may be considered for disability leave benefits:

- Non-work-related injury or illness
- Mental health conditions
- Substance abuse conditions

(Note: An employee must be receiving ongoing treatment, which prevents the employee from working.)

How to apply

An employee has 20* calendar days from their date last worked to obtain and complete, in its entirety, a disability application with their agency's personnel office or benefits coordinator. It is the employee's responsibility to provide from their respective treating source(s), medical documentation to substantiate the cause, nature and extent of the disabling illness, injury or condition.

*Contract exceptions for filing FOP 46 & FOP 48 - please refer to your contract.

Payment while on disability leave

As a State of Ohio employee, there is no cost to you for disability leave benefits. Each state agency pays a percentage of its payroll into the disability fund. Disability benefits shall be paid at 67 percent of the employee's base rate of pay for the maximum 12 months of eligibility* whether the employee files a new, subsequent-related or subsequent-unrelated claim. The employer's and employee's share of the health, life and other insurance benefits will be paid by the employer during the period the employee is pending and receiving disability leave benefits. The employee will be responsible for paying their portion of retirement contributions.

*Contract exceptions for length of lifetime maximum effect percentage paid at what month – Attorney General, Auditor, Treasurer and Secretary of State.



WORKERS' COMPENSATION

Workers' compensation is a 'no-fault' system that compensates employees for work-related injuries or illnesses. Workers' compensation provisions can be found in the Ohio Constitution Article II, Section 35; Ohio Revised Code Chapters 4121 and 4123; and Ohio Administrative Code Chapters 4121, 4123 and 4125.

When an Injury Occurs

- Reporting: follow your agency's policy on reporting incidents and injuries.
- Obtain medical care promptly. If you wish to request Salary Continuation or Occupational Injury Leave you must use an approved provider. Your agency or Managed Care Organization (MCO) can provide you with names of approved providers in your area who can assist. Not adhering to agency reporting guidelines/policy when applying for Salary Continuation or Occupational Injury Leave may result in denial of benefits. If emergency treatment is required, go immediately to the nearest emergency facility and follow up with an approved provider to obtain benefits.
- Complete an Accident or Illness Report (ADM 4303).

Employer-Provided Benefits for Worker's Compensation Claims

Salary Continuation

- Provides the injured employee with 100 percent of his/her regular rate of pay in lieu of workers' compensation temporary total benefits if an approved provider is used. Benefits are not to exceed 480 hours.
- Once salary continuation benefits are exhausted, you may be eligible to receive lost time benefits from the Bureau of Workers' Compensation (BWC). You and your attending physician will need to file a Request for Temporary Total Compensation (Form C-84).
- Payments for salary continuation are included in your bi-weekly pay.
- Filing a Claim:
 - You must file an Accident or Illness Report using the ADM 4303 form.
 - Note that there are submission deadlines. Employees have 20 days to simultaneously file a workers' compensation claim.

Occupational Injury Leave

- Provides the injured employee with 100 percent of his/her regular rate of pay in lieu of workers' compensation benefits if an approved provider is used.
- Available to employees who are injured in the line of duty as a result of a bodily injury sustained by an inmate, client, patient, resident, youth or student, and is limited to specific agencies. You may refer to the Ohio Revised Code, the Ohio Administrative Code or your union contract for specific information.

CONTINUED ON PAGE 24 ►



- Benefits are limited to a maximum number of hours determined by your bargaining unit. Non-bargaining unit employees have a maximum of 960 hours.
- If your occupational injury leave benefits are exhausted, you may be eligible to receive lost time benefits from the Bureau of Workers' Compensation (BWC). You and your attending physician will need to file a Request for Temporary Total Compensation (Form C-84).
- Bargaining unit employees may appeal a denied Occupational Injury Leave decision claim and should refer to the appeal procedure in their union contract.
- Appeals should be sent to the DAS Office of Collective Bargaining within 20 days of the denial.
- Exempt employees do not have grievance rights. They may appeal a denied Occupational Injury Leave decision by completing the 'Exempt Occupational Injury Leave Appeal Form' located on the Benefits website at: das.ohio.gov/healthcareforms. Instructions are located on the form. The decision by Benefits Administration Services, however, is final.
- Payments for occupational injury leave are included in your bi-weekly pay.

Disability Advancement

Available only if the BWC denies your initial claim for workers' compensation benefits and you are appealing the decision. If you do not intend to appeal, you may file for disability benefits within 20 days of the denial order.

To file for disability advancement, complete the disability application and disability agreement. Submit them with your denial order to your personnel office within 20 days of the notification of denial.

You may receive the advancement for a maximum of 12 weeks. If your workers' compensation claim is approved through the appeal process or by a settlement, you will be required to pay back all of the money that has been advanced, regardless of the amount received from the BWC or the settlement.

Leave Buy Back

Some bargaining unit employees have the option of buying back leave time that was used while waiting for a workers' compensation claim to be approved. See your bargaining unit contract to determine your eligibility.

A wage advancement agreement is a contract between you and your employer that states the amount of leave time that you will buy back.

You may buy leave time back either with or without a wage advancement agreement.

LONG TERM CARE COVERAGE

Long Term Care is an employee pay all program offered through Prudential Long Term Care Solid Solutions (The Prudential Insurance Company of America).

Long Term Care is the help or supervision provided for someone with severe cognitive impairment or the inability to perform daily living activities, including bathing, dressing, eating, toileting, transferring and continence. Services may be provided at home or in a facility – and care may be provided by a professional or informal caregiver.

You may be eligible for long term care benefits if you are between the ages of 18 and 84, either a permanent full-time employee or permanent part-time employee, and working 20 hours or more per week, who is actively at work. Newly hired employees who meet the eligibility requirements can enroll without proof of good health within 31 days of their hire date.

If you do not enroll when initially eligible, you may apply for long-term care insurance anytime. You must provide proof of good health, however, and be approved by the insurance carrier, Prudential Life Insurance Company of America, to obtain coverage.

Request an enrollment kit at: prudential.com/gltcweb.



Flexible Spending Accounts (FSA)



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KNOW

Flexible Spending Account
Fringe Benefits Management Company (FBMC)
1.800.342.8017
www.myfbmc.com

Flexible Spending Accounts (FSA)

Health Care Spending Account

The health care spending account (HCSA) is a tax-favored account which provides the opportunity for eligible employees to defer on a pre-tax basis up to a maximum of \$3,000 into an account to pay for eligible expenses not paid by their health care, vision or dental plans. There is no administrative fee for participants. The myFBMC CardSM, which facilitates payment of eligible health care expenses, is issued to all participating employees. For more detailed information about eligible expenses, the HCSA or the debit card, please visit: www.myfbmc.com, the website for the State of Ohio's program vendor, Fringe Benefits Management Company, a division of WageWorks.

Dependent Care Spending Account

The dependent care spending account (DCSA) is a tax-favored account that provides the opportunity for eligible employees to defer on a pre-tax basis up to a maximum of \$5,000 (depending on tax status) into an account to pay for eligible child care, dependent care and eldercare expenses. For more detailed information about the DCSA, please visit: www.myfbmc.com, the website for the State of Ohio's program vendor, Fringe Benefits Management Company, a division of WageWorks.

Enrollment Eligibility

Health Care Spending Account (HCSA)

- You must be a permanent part-time or permanent full-time employee with sufficient pay to cover the election amount.
- May enroll within 30 days of the hire date, if no probationary period.
- May enroll within 30 days of completing probation, if there is a probationary period.

It is not necessary to be enrolled in the State of Ohio's health benefits to participate in the HCSA. If both a husband and wife are state employees, both may participate in the HCSA as separate individuals.

Dependent Care Spending Account (DCSA)

- You may enroll within 30 days of your hire date if you are a permanent part-time or permanent full-time employee with sufficient pay to cover the election amount.
- Employee has a qualifying dependent(s).

If an employee does not enroll within the timeframes noted, other opportunities to enroll are as follows:

- During the annual open enrollment period
- Following a change in status: According to the IRS regulations governing Section 125 Cafeteria Plans a change can be made to the employee's HCSA and DCSA election. However, the proposed change must be consistent with the type of change experienced. Contributions and benefit changes must be an appropriate result of the change in status. The timeframe for notification is within thirty (30) days of the qualifying event.

For more detailed information about Flexible Spending Accounts, please visit: das.ohio.gov/flexible.spendingaccount or the State of Ohio's program vendor, Fringe Benefits Management Company, a division of WageWorks, at: www.myfbmc.com.

Commuter Choice Parking and Transit Program

The Commuter Choice program covers two types of commuting expenses:

- Transportation expenses, which include qualified fares for riding buses, trains, subways, ferries and other types of mass transportation or vanpools.
- Parking expenses which include the cost of parking at or near your place of work or at or near a place from which you commute to work by mass transit, such as a park-and-ride lot.

When you enroll in Commuter Choice for eligible transportation expenses, you are authorizing the third-party administrator, Fringe Benefits Management Company (FBMC), to purchase your public transportation fare passes (i.e. bus pass) and vanpool passes, directly from your transportation provider. Visit: das.ohio.gov/commuterchoice for more information.

The 2011 IRS monthly allowable dollar limit for transit is \$230. When you enroll for the Commuter Choice transit benefit, the fare pass will be delivered directly to your home address.

The 2011 IRS monthly allowable dollar limit for parking is \$230. When you enroll for the Commuter Choice parking benefit, FBMC will pay your parking service directly.

Should your parking and/or transit expenses exceed the IRS monthly allowable dollar limit, you may have additional dollars withheld on an after-tax basis to pay your expenses that exceed the IRS dollar limit.

Effective Jan. 1, 2012, please visit: das.ohio.gov/benefits for current rate information.

GLOSSARY

When reviewing information about your health care coverage options, it's helpful to understand some of the basic terms and concepts.

Classified Employee: is subject to examination and may have employment protection under the terms of Ohio civil service laws or a collective bargaining unit agreement. Classified employees also are certified or provisional. A certified employee has either passed a civil service exam and has been appointed from an eligible list or has been in the same classification series for two years without an opportunity to take and pass an exam. A provisional employee is hired without taking a formal civil service examination and has not been in the same classification series for two years.

Coinsurance: The percentage of eligible expenses that the health care plan pays after the annual deductible is met. For example, an 80 percent coinsurance rate means you pay 20 percent and the plan pays 80 percent.

Copay: A specified dollar amount you pay to a health care provider or pharmacy for eligible expenses such as office visits and prescriptions. Copays do not count toward your annual deductible.

Deductible: The amount you pay for eligible expenses each plan year before the plan begins to pay anything.

Employee Contribution: The portion of the total premium that you pay through pre-tax payroll deductions for your insurance coverage.

Exempt Employee: means an appointment to a position, which is not represented by a labor union. Employees are usually exempt from union representation because they are supervisors, in positions of a confidential or fiduciary nature, or not in permanent appointments.

Out-of-pocket Maximum: The cap or maximum amount you pay for eligible out-of-pocket health care expenses during the plan year. After your out-of-pocket expenses reach the maximum, the plan pays 100 percent of any additional eligible expenses for the remainder of the plan year. Check with your TPA to determine if health plan copays apply. Prescription copays do not apply to the out-of-pocket maximum.

Preferred Provider Organization (PPO): When you enroll in the Ohio Med PPO, you may visit any doctor and receive benefits. However, the benefit is less when you use providers who are not part of the PPO network. Ohio Med is available to all employees eligible for medical care.

State Contribution: The portion of the total premium the state pays to provide employees with coverage.

Total Premium: The combination of the employee contribution and the state contribution.

Unclassified Employee: is not subject to examination and serves at the pleasure of the appointing authority. Unclassified employees sometimes are in managerial positions, which have significant authority to act on behalf of the agency. External interim, intermittent, seasonal, temporary, and student intern appointments are also unclassified.

Union-represented Employee: Also known as, a Bargaining Unit Employee, is represented by a labor union and covered by the terms of a collective bargaining agreement.

Legal Notices



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KNOW

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2011. You should contact your state for further information on eligibility:

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: health.hss.state.ak.us/dpa/programs/medicaid Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: www.colorado.gov Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: www.arkidsfirst.com Phone: 1-888-474-8275	Website: www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268
GEORGIA – Medicaid	MISSOURI – Medicaid
Website: dch.georgia.gov Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IDAHO – Medicaid and CHIP	MONTANA – Medicaid
Medicaid Website: accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084

INDIANA – Medicaid	NEBRASKA – Medicaid
Website: www.in.gov/fssa Phone: 1-800-889-9948	Website: www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	NEVADA – Medicaid and CHIP
Website: www.dhs.state.ia.us/hipp Phone: 1-888-346-9562	Medicaid Website: dwss.nv.gov Medicaid Phone: 1-800-992-0900 CHIP Website: www.nevadacheckup.nv.org CHIP Phone: 1-877-543-7669
KANSAS – Medicaid	
Website: www.khpa.ks.gov Phone: 1-800-792-4884	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 1-800-356-1561 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557	
MASSACHUSETTS – Medicaid and CHIP	NEW MEXICO – Medicaid and CHIP
Medicaid & CHIP Website: www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	Medicaid Website: www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MINNESOTA – Medicaid	
Website: www.dhs.state.mn.us Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	
NEW YORK – Medicaid	TEXAS – Medicaid
Website: www.nyhealth.gov/health_care/medicaid Phone: 1-800-541-2831	Website: www.gethipptexas.com Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	UTAH – Medicaid
Website: www.nc.gov Phone: 919-855-4100	Website: health.utah.gov/upp Phone: 1-866-435-7414
NORTH DAKOTA – Medicaid	VERMONT – Medicaid
Website: www.nd.gov/dhs/services/medicalserv/medicaid Phone: 1-800-755-2604	Website: www.greenmountaincare.org Phone: 1-800-250-8427

OKLAHOMA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: www.famis.org CHIP Phone: 1-866-873-2647
OREGON – Medicaid and CHIP	WASHINGTON – Medicaid
Medicaid & CHIP Website: www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Website: hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: www.wvrecovery.com/hipp.htm Phone: 304-342-1604
RHODE ISLAND – Medicaid	WISCONSIN – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: www.scdhhs.gov Phone: 1-888-549-0820	Website: www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more states have added a premium assistance program since Jan. 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Ext. 61565



Continuation Coverage Rights Under COBRA

INTRODUCTION

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It also can become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, you should review the plan's summary description or contact the plan administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the plan because of the following qualifying event:

- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

WHEN IS COBRA COVERAGE AVAILABLE?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify your agency HR representative within 60 days after the qualifying event occurs.

HOW IS COBRA COVERAGE PROVIDED?

Once your agency HR representative receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA continuation coverage for the employee's spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying

Legal Notices

event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the plan administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Requests for disability extensions must be made in writing to the COBRA administrator, see Plan Contact Information below for address and phone number. You must include a copy of your most recent SSA disability approval letter. If your disability is not certified by the SSA, you do not qualify for the extension.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, the Employee Retirement Income Security Act, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at: dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, you should keep the plan administrator informed of any changes in the addresses of family members. You also should keep a copy, for your records, of any notices you send to the plan administrator.

PLAN CONTACT INFORMATION:

COBRA Administrator
Benefits Administration Services
30 E. Broad Street, 27th Floor
Columbus, OH 43215
614.466.8857 or 1.800.409.1205

Women's Health and Cancer Rights Act of 1998: Notice of Rights

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. The terms of WHCRA provide:

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for--

1. all stages of reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

If you have any questions about the State of Ohio's plans provisions relating to the Women's Health and Breast Cancer Rights Act of 1998, contact HR Customer Service at 614.466.8857 or 1.800.409.1205.

Newborns' and Mothers' Health Protection Act

Under the provisions of The Women's and Newborns' Act, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection

The Ohio Med PPO generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, please see the contact numbers for Medical Mutual and UnitedHealthcare below.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Medical Mutual or UnitedHealthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a professional in our network who specializes in obstetrics or gynecology. The professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating professionals who specialize in obstetrics or gynecology, contact Medical Mutual at 1.800.822.1152 or UnitedHealthcare at 1.877.440.5977.

Creditable Coverage Disclosure:

Important Notice from the State of Ohio About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage effective July 1, 2011 to June 30, 2012, with the State of Ohio and information about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage

and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

MEDICARE

1. Prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The State of Ohio has determined that the prescription drug coverage offered by Catalyst Rx is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Nov. 15 through Dec. 31. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current State of Ohio coverage will not be affected. The State of Ohio has determined that the prescription drug coverage offered by Catalyst Rx is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Go to: das.ohio.gov/prescriptiondrug for more details on your prescription benefits.

If you decide to join a Medicare Drug Plan and drop your current state medical coverage, be aware that you and your dependents will not be able to get this coverage back unless you experience a qualifying event or sign up during open enrollment.

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WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with the State of Ohio and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least one percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the State of Ohio changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage, visit: medicare.gov.

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1.800.633.4227)
TTY users should call 1.877.486.2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at: socialsecurity.gov or call them at 1.800.772.1213 (TTY 1.800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

STATE OF OHIO
DAS Benefits Administration
Prescription Drug Benefits Manager
30 East Broad, 27th Floor
Columbus, OH 43215
1.800.409.1205

While efforts have been made to ensure the accuracy of the information contained in this document, nothing contained in this document is intended to modify or alter your rights or obligations under federal or state law, or for employees covered by a collective bargaining agreement, the provisions of that agreement. To the extent anything contained in this document conflicts with federal or state law or any applicable collective bargaining agreement (for employees covered by such an agreement), the terms and conditions of the federal or state law, or the applicable collective bargaining agreement, control. Additionally, as the laws and policies regarding employee benefits change from time to time, you should refer to the State of Ohio's Benefits website for current and updated information regarding your benefits at: das.ohio.gov/benefits.

Health and Other Benefits Contacts

All Employees

MEDICAL

MEDICAL MUTUAL

1.800.822.1152
medmutualstateohioemployee.com
Group Number: 228000

UNITEDHEALTHCARE

1.877.440.5977
myuhc.com
Group Number: 702097

PRESCRIPTION DRUG CATALYST RX

1.866.854.8850
catalystrx.com

BEHAVIORAL HEALTH & SUBSTANCE ABUSE UNITED BEHAVIORAL HEALTH

1.800.852.1091
liveandworkwell.com
Group Number: 00832
Code: 00832

TAKE CHARGE! LIVE WELL! APS HEALTHCARE

1.866.272.5507
stateofohio.apshealthcare.com

24-HOUR NURSE ADVICE LINE

1.866.272.5507, option 3

FLEXIBLE SPENDING ACCOUNT

FRINGE BENEFITS
MANAGEMENT COMPANY (FBMC)
1.800.342.8017
myfbmc.com

Other Benefits

DELTA DENTAL OF OHIO

1.800.524.0149
deltadentaloh.com
Group Number: 9273-0001 (PPO)
Group Number: 9273-1001 (Premier)

VISION SERVICE PLAN (VSP)

1.800.877.7195
vsp.com
Group Number: 12022518

EYEMED VISION CARE

1.866.723.0514
eyemedvisioncare.com
Group Number: 9676008

BASIC LIFE INSURANCE

The Standard
1.866.415.9518
standard.com/mybenefits/ohio

SUPPLEMENTAL LIFE INSURANCE

Prudential Life Insurance
1.800.778.3827
Group Number: LG-93046

OTHER CONTACTS LONG TERM CARE INSURANCE (EXEMPT AND UNION-REPRESENTED)

Prudential Long Term
Care Solid Solutions
1.800.732.0416
Prudential.com/GLTCWEB
Group Name: stateofohio
Access Code: buckeyes
Group Number: LT-50636-OH

OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES

HR Customer Service
614.466.8857
1.800.409.1205
HRCustomerService@das.state.oh.us
das.ohio.gov/benefits

Union Represented Employees

VISION SERVICE PLAN

1.800.877.7195
Group Number: 12022914

EYEMED VISION CARE

1.866.723.0514
Group Number: 9674813

DELTA DENTAL OF OHIO

1.877.334.5008
Group Number: 1009

PRUDENTIAL LIFE INSURANCE

1.800.778.3827
Group Number: LG-01049

WORKING SOLUTIONS PROGRAM

1.800.358.8515
Group Number: 4718

HYATT LEGAL SERVICES

1.800.821.6400
Group Number: 49000010

UNION BENEFITS TRUST (UBT)

614.508.2255
1.800.228.5088
Union-represented employees can
access plan information at:
benefitstrust.org

TIP: When placing your calls, please ensure you have the documentation you might need during the call:

- Group Number
- Employee ID Number
- Explanation of Benefits (EOB) if call is regarding claims.

2011/2012 AT A GLANCE

2011

JULY

- New benefits year begins July 1

AUGUST

- Dental Health Month

SEPTEMBER

- Get a flu shot
- National Cholesterol Education Month

OCTOBER

- Flexible Spending Account Open Enrollment
- Breast Cancer Awareness Month
- National Depression Screening Month

NOVEMBER

- *Take Charge! Live Well!* assessments must be completed by Nov. 30
- National Diabetes Month

DECEMBER

- Use your remaining Flexible Spending Account money

2012

JANUARY

- W-2's are coming
- New Flexible Spending Account plan year

FEBRUARY

- Heart Health Month

MARCH

- Flexible Spending Account deadline for 2011 claims

APRIL

- Prepare for Benefits Open Enrollment, update your personal data

MAY

- Benefits Open Enrollment

JUNE

- *Take Charge! Live Well!* year ends June 30
- Annual exams for kids





Ohio.gov | The State of Perfect Balance

