Pathways

your path to wellness

Brought to you by OhioDAS and the Joint Health Care Committee

SPRING EDITION

STATE OF OHIO 2010 OPEN ENROLLMENT

OPEN ENROLLMENT 2010

2010-2011 PLAN YEAR

For more information visit the following web pages:
Open Enrollment - das.ohio.gov/OpenEnrollment
Open Enrollment Pathways - das.ohio.gov/OEPathways

UNION BENEFITS TRUST

Ohio The State of Perfect Balance

OhioDAS Ohio Department of Administrative Services

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Ted Strickland,
Governor

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Ohio Department of Administrative Services

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Benefits Administration Services

das.ohio.gov/benefits

WELCOME TO OPEN ENROLLMENT

The open enrollment period for benefit changes will begin Monday, May 3 and end at midnight Sunday, May 16. During this time, eligible employees have the opportunity to make benefit elections or changes to their medical, dental and vision coverage. In addition, you can enroll in or change your Supplemental Life benefits (see page 14 for enrollment instructions). Enrollment for Flexible Spending Accounts occurs in the fall so enrollment information will be provided at a later date.

This edition of Pathways provides you with a brief explanation of your plan options, important changes for the coming year, steps on how to make your open enrollment elections, and benefits comparison and rate charts.

All choices made during Open Enrollment will be effective July 1, 2010. You will not have another opportunity to enroll yourself or eligible dependents for benefits or make changes to your elections until July 1, 2011, unless you have a qualifying life event, such as marriage, divorce or the birth or adoption of a child. For a complete list of qualifying events go to ***das.ohio.gov/QualifyingEvents***.

Dependents who are enrolled in your medical, dental and vision plans should be reviewed during Open Enrollment. This is an opportunity to ensure that they still meet the eligibility requirements of a dependent. See the requirements at: ***das.ohio.gov/EligibilityRequirements***.

In this edition of Pathways, you will notice several enhancements from previous open enrollment editions. First, rates for part-time employees have been added. At the back of this Pathways, you will find required legal notices related to your benefits and a glossary of common benefit terms.

Please thoroughly read this open enrollment edition of Pathways before making your 2010 - 2011 benefits selections.

Please note that the material in this Pathways is for informational purposes. It is intended only to highlight the main benefits eligibility policies and coverage information. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the plan documents, the plan documents govern.

HOW YOU CAN HELP CONTROL HEALTH CARE COSTS

The State of Ohio's health plans are self-funded. This means that the cost of your benefits is funded by the contributions from you and your agency. All benefit claims are paid for by these contributions. Your medical plan does not pay for your claims - it reviews claims and processes payments, for which it receives an administrative fee. When the amount of claims is greater than the amount of the contributions from employees and agencies, then your medical costs go up. It is up to each of us to use the benefits wisely. Do your part by staying healthy, evaluating your options when you need care and avoiding unnecessary care.

Three Steps to Enroll

1. Review your benefit options by carefully reading this edition of Pathways. If you have questions, contact your agency benefits representative or DAS HCM Customer Service Unit at 1.800.409.1205.

2. Enroll or make changes for medical, dental and vision online through eBenefits or by paper.

   A. ONLINE – Go to ***ebenefits.ohio.gov*** to access the OAKS Self Service module for benefits.

   - Enter your **OAKS Employee ID number and password.**
     - If you have forgotten your Employee ID number or your password, contact the DAS HCM Customer Service Unit at ***dashrd.hcmOAKSsupport@das.state.oh.us*** or call 614.466.8857 or 1.800.409.1205.
   - Click on **Self Service**.
   - Click on **Benefits**, then **Benefits Summary**, then **Enroll in Benefits**.
   - For detailed instructions on how to enroll or make changes online, go to ***das.ohio.gov/EnrollmentInstructions***.
   - Online open enrollment available May 3 to May 16:

May 3 to 7, and May 10 to 14	All day except 7 to 9 p.m.
Saturday, May 8	All day except 4 to 6 p.m.
Sunday, May 9	All day except 4 p.m. to midnight
Saturday, May 15	All day except 4 to 6 p.m.
Sunday, May 16	All day ending at midnight

   B. PAPER – Obtain a paper Medical Benefit Enrollment and Change Form (ADM 4717) and/or a Dental and Vision Enrollment and Change Form for exempt employees (ADM 4720) from your agency's human resources office. Or access the form online at ***das.ohio.gov/benefits*** by clicking on the 2010 Benefits Open Enrollment link.

3. Submit your enrollment or changes

   A. ONLINE – Make and submit your selections no later than midnight Sunday, May 16. Make sure your online changes were correctly submitted. At the end of the process you will receive a confirmation message.

   B. PAPER – Give your completed and signed Medical and/or Dental and Vision Enrollment and Change Form to your agency's human resources office by 4 p.m. Friday, May 14.

Note: After open enrollment ends, you will receive a confirmation letter in the mail in early June.

Want to keep your current benefits coverage?

If you want to remain in the same health care plan(s) and you have no changes regarding dependents for the 2010 – 2011 plan year, you do not need to take any action during the open enrollment period. Your current elections will automatically carry over to the new plan year.

What's New

CHANGES FOR THE 2010-2011 BENEFITS PLAN YEAR	
Bi-Weekly Premium Rates	See pages 8 and 9 for the employee premium rates beginning July 1. The rate tables now include rates for part-time employees.
Adding dependents to coverage	You must provide proof of eligibility to add dependents to coverage. You can access dependent eligibility and documentation requirements at: *das.ohio.gov/EligibilityRequirements*.
House Bill 1 (HB1) Coverage for Dependents	Ohio House Bill 1 (HB1) allows employees to provide medical coverage for eligible dependents up to age 28 for an additional cost. You can access HB1 eligibility and documentation requirements at: *das.ohio.gov/EligibilityRequirements*.
Michelle's Law	Dependent child who is a student at a postsecondary institution and who is on a medically necessary leave of absence may continue coverage up to one year. You can access Michelle's Law eligibility and documentation requirements at: *das.ohio.gov/EligibilityRequirements*.
Mental Health Parity and Addiction Equity Act of 2008	Detailed information about required changes will be forthcoming as the plan designs are finalized.
Payroll schedule change for FY2011	The first FY2011 bi-weekly deduction will be taken out of the July 2 paycheck (pay period ending June 19, 2010). This change will allow for alignment with state financial systems.

Ohio House Bill 1 (HB1) allows employees to cover eligible dependents up to age 28 for an additional cost. You can access HB1 eligibility and documentation requirements at: das.ohio.gov/EligibilityRequirements.

Note: House Bill 1 (HB1) does not apply to dental and vision coverage.

Eligibility for Benefits

When you view your benefits information in the Ohio Administrative Knowledge System (OAKS) you see only the medical, dental and vision plans for which you are eligible. In OAKS, go to Self Service > Benefits > Benefits Summary.

EMPLOYEES

- **Medical** – Most state employees are eligible for medical coverage (including pharmacy and mental health) effective the first day of the month following their date of hire.
- **Dental and Vision** – Exempt and union-represented employees are eligible to enroll in dental and vision coverage after completing one full year of continuous state service.
- **Basic Life** – Exempt and union-represented employees are eligible for basic life coverage after completing one full year of continuous state service. Enrollment is not required.
- **Supplemental Life** – Exempt and union-represented employees are eligible for supplemental life coverage effective the first day of the month following their date of hire. You must enroll directly with Prudential.

DEPENDENTS

To view the detailed eligibility and documentation requirements for all dependents, please go to ***das.ohio.gov/EligibilityRequirements***.

Examples of eligible dependents include:

- An employee's legal spouse
- Dependent child

AGE	**Eligible Dependent** (Medical/Dental/Vision)	**HB1 Dependent** (medical only)
0-18	Yes, if requirements are met	No
19-22	Yes, if requirements are met	Yes, if requirements are met
23-27	No	Yes, if requirements are met

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 HR representative 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 HR representative within 60 days of the ineligibility date. Enrollment of an ineligible dependent may result in loss of benefits, disciplinary action and/or repayment of claims.*

Choosing Your Medical Coverage

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

When selecting medical insurance, choosing the network of providers is one of the most important decisions you'll make. As a state employee, you have the option to select a Preferred Provider Organization (PPO) or a Health Maintenance Organization (HMO). Both a PPO and an HMO consist of a group of doctors, hospitals and other providers organized into a network to deliver services to members at discounted rates.

See the Glossary on page 18 for more information.

Out-of-Pocket Costs of Your Medical Plan Options

Plan Name		Annual Deductible	Your Copayments (Office Visits)	Coinsurance	Your Out-of-Pocket Maximum
Ohio Med (PPO) [1]	Network	$200 single $400 family	$20	You pay 20% plan pays 80%	$1,500 single $3,000 family
	Out-of-Network	$400 single $800 family	$30	You pay 40% plan pays 60%[2]	$3,000 single $6,000 family[3]
Aetna (HMO)	Network	$200 single $400 family	$20	You pay 20% plan pays 80%	$1,500 single $3,000 family
Paramount (HMO)	Network	$200 single $400 family	$20	You pay 20% plan pays 80%	$1,500 single $3,000 family
The Health Plan (HMO)	Network	$200 single $400 family	$20	You pay 20% plan pays 80%	$1,500 single $3,000 family
UnitedHealthcare (HMO)	Network	$200 single $400 family	$20	You pay 20% plan pays 80%	$1,500 single $3,000 family

[1] For employees stationed outside Ohio, please refer to the health plan for more information.

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

[3] Applies to non-network providers or a mix of network and non-network providers. If your non-network provider charge is greater than the Ohio Med allowance, your out-of-pocket costs will be more.

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

The chart below highlights the major differences between the medical plan options.

Medical Plan Coverage Differences

Plan Feature	Ohio Med PPO[1]		Aetna HMO	Paramount HMO	The Health Plan HMO	UnitedHealthcare HMO
	In-Network	Out-of-Network				
Out-of-Network Services Covered	Not Applicable	Yes	No[2]	No[2]	No[2]	No[2]
Allergy Testing & Treatment	• $20 copay per office visit. • Plan pays 80% for injections after deductible.	• $30 copay per office visit. • Plan pays 60% for injections after deductible.	• $20 copay for office visit. • Plan pays 80% after deductible.	• $20 copay for office visit. • Plan pays 80% after deductible.	• $20 copay for office visit.	• $20 copay for office visit. • Plan pays 80% after deductible.
Chiropractic Care	• Plan pays 80% after deductible. • Unlimited visits.	• Plan pays 60% after deductible. • Unlimited visits.	• $20 copay per visit. • Plan pays 80% after deductible. • 20-visit limit per benefit year for spinal manipulation.	• $20 copay per visit. • 40-visit limit per year or $750 maximum benefits.	• $20 copay per visit. • 20-visit limit per year.	• $20 copay per visit. • Plan pays 80% after deductible. • 20-visit limit per year.
Hearing Loss (Accidental, Injury or Illness)	• Plan pays 80% after deductible for hearing aids at a network provider; 60% after deductible at an out-of-network provider. • No lifetime maximum. • Exams and follow-up services included in coverage.		• $20 copay for exams and follow-up services. • Plan pays 50% after deductible for hearing aids up to $1,000 lifetime maximum.	• $20 copay for exams and follow-up services. • Plan pays 80% after deductible for hearing aids. • No lifetime maximum.	• $20 copay for exams and follow-up services • Plan pays 80% after deductible for hearing aids. • Unlimited lifetime maximum for office visits and testing. • Hearing aids limited to one per lifetime.	• $20 copay for exams and follow-up services. • Plan pays 80% after deductible for hearing aids. • No lifetime maximum.
Hearing Loss (Natural)	• Plan pays 50% after deductible for hearing aids up to $1,000 lifetime maximum. • Exams and follow-up services included in coverage.		• $20 copay for exams. • Plan pays 50% after deductible for hearing aids up to $1,000 lifetime maximum.	• $20 copay for exams and follow-up services. • Plan pays 50% after deductible for hearing aids up to $1,000 lifetime maximum.	• $20 copay for exams and follow-up services. • Plan pays 80% after deductible for hearing aids. • Unlimited lifetime maximum for office visits and testing. • Hearing aids limited to one per lifetime.	• $20 copay for exams and follow-up services. • Plan pays 50% after deductible for hearing aids up to $1,000 lifetime maximum.
Physical, Occupational and Speech Therapy	• Plan pays 80% after deductible. • Unlimited visits.	• Plan pays 60% after deductible. • Unlimited visits.	• $20 copay per visit. • Plan pays 80% after deductible for up to 30 visits, per condition, per year. • 30 visit limit per year for speech therapy.	• Plan pays 80% after deductible for up to 30 visits per condition year. • 30 visit limit per year for speech therapy.	• Inpatient: Plan pays 80% after deductible. • Outpatient: $20 copay per visit. • 20-visit limit per occurrence.	• Plan pays 80% after deductible. • 30-visit limit per year physical and occupational therapy combined.
Urgent Care	• $25 copay per visit. • Plan pays 80% after deductible.	• $30 copay per visit. • Plan pays 60% after deductible.	• $25 copay per visit. • Plan pays 80% after deductible.	• $25 copay per visit. • Plan pays 80% after deductible.	• $25 copay per visit. • Plan pays 80% after deductible.	• $25 copay per visit. • Plan pays 80% after deductible.

[1] For employees stationed outside Ohio, please refer to the health plan for more benefits information.
[2] HMOs do not have an out-of network benefit except for emergencies.

The chart below highlights the benefits/services that are the same across all medical plans.

In-Network Core Benefits for All Medical Plans	
Benefit/Service	**Coverage Levels**
Ambulance Service	• Covered at 80%.
Diabetic Supplies and Insulin	• Covered at 100% upon participation in *Take Charge! Live Well!* chronic condition management program. • Covered at 80% with no participation in the chronic condition management program.
Dietitian Services	• Covered at 80%; covers the cost of two medically necessary visits with a network dietitian per condition per year; some plans may require a $20 copay.
Durable Medical Equipment	• Covered at 80%. • Includes equipment such as hospital beds, wheelchairs, crutches and oxygen equipment; check with plan to determine what equipment is covered.
Emergency Room	• Covered at 80%; plans require a $75 copay, which is waived if patient is admitted.
Preventive Exams & Screenings	• Most preventive care covered at 100% (see Preventive Care chart on page 10). • Covered at 80% for diagnostic screenings. • Age restrictions may apply.
Immunizations	• Most are covered at 100% (see Preventive Care chart on page 10).
Diagnostic, X-Ray and Lab Services	• Most are covered at 100% in conjunction with preventive services; covered at 80% if not in conjunction with preventive services.
Home Health Care	• Covered at 80%; limit of 100 visits or 180 days for all plans.
Hospice Services	• Covered at 100% with no copay, time or dollar limitations.
Infertility Testing	• Covered at 80%; some plans may require a $20 copay. • Coverage includes testing only.
Inpatient and Outpatient Services	• Covered at 80%. • Includes medical/surgical care while hospitalized and services from a personal physician, anesthesiologist or pathologist while hospitalized.
Maternity - Delivery	• Covered at 80%.
Maternity - Prenatal Care	• Office visits covered at 100% when billed seperately from delivery; tests/procedures covered at 80%.
Prostheses	• Covered at 80%; covers initial and replacement prosthetic devices, both internal and external devices.
Skilled Nursing Facility	• Covered at 80%; 180-day limit, additional days covered at 60%.

Medical Rates

FULL-TIME EMPLOYEE DEDUCTIONS						
	Full-Time / Biweekly-Paid Employee Deductions[2]			Full-Time / Monthly-Paid Employee Deductions[3]		
	Employee Share	State Share	Total	Employee Share	State Share	Total
OHIO MED				**OHIO MED**		
Single	$30.35	$165.24	$195.59	$63.58	$358.02	$421.60
Family Minus Spouse	$83.07	$454.01	$537.08	$174.00	$983.68	$1,157.68
Family Plus Spouse[1]	$89.07	$454.01	$543.08	$186.50	$983.68	$1,170.18
AETNA				**AETNA**		
Single	$34.96	$161.04	$196.00	$73.22	$348.92	$422.14
Family Minus Spouse	$95.70	$422.46	$538.16	$200.50	$958.66	$1,159.16
Family Plus Spouse[1]	$101.69	$442.46	$544.15	$213.00	$958.66	$1,171.66
PARAMOUNT				**PARAMOUNT**		
Single	$30.51	$146.55	$177.06	$63.92	$317.52	$381.44
Family Minus Spouse	$83.50	$402.60	$486.10	$174.92	$872.30	$1,047.22
Family Plus Spouse[1]	$89.49	$402.60	$492.09	$187.42	$872.30	$1,059.72
THE HEALTH PLAN				**THE HEALTH PLAN**		
Single	$32.67	$164.98	$197.65	$68.48	$357.46	$425.94
Family Minus Spouse	$89.41	$453.29	$542.70	$187.48	$982.14	$1,169.62
Family Plus Spouse[1]	$95.41	$453.29	$548.70	$199.98	$982.14	$1,182.12
UNITEDHEALTHCARE				**UNITEDHEALTHCARE**		
Single	$33.65	$160.10	$193.75	$70.46	$346.88	$417.34
Family Minus Spouse	$92.10	$439.85	$531.95	$192.88	$953.02	$1,145.90
Family Plus Spouse[1]	$98.09	$439.85	$537.94	$205.38	$953.02	$1,158.40
ADDITIONAL AMOUNTS FOR EACH HOUSE BILL 1 DEPENDENT				**ADDITIONAL AMOUNTS FOR EACH HOUSE BILL 1 DEPENDENT**		
Ohio Med	$69.57	$0.00	$69.57	$150.74	$0.00	$150.74
Aetna	$69.66	$0.00	$69.66	$150.93	$0.00	$150.93
Paramount	$62.93	$0.00	$62.93	$136.35	$0.00	$136.35
The Health Plan	$70.29	$0.00	$70.29	$152.29	$0.00	$152.29
UnitedHealthCare	$68.87	$0.00	$68.87	$149.21	$0.00	$149.21

1. Family plus spouse rates above include a charge of $5.77 per biweekly pay or $12.50 per monthly pay to cover a spouse.

2. These rates represent the total amount that will be deducted from each paycheck. They include the following: communication surcharge, mental health charge and the FY 2010 rate adjustment.

3. These rates represent the total amount that will be deducted from each paycheck. They include the communication surcharge and mental health charge.

Differences in plan rates are the result of each medical plan's design, claims history and administrative fees. Medical plan administrative fees are a portion of the rates, and the state pays for 85 percent of the lowest administrative fee. If you choose a plan that has a higher administrative fee, you will pay 15 percent of the lowest administrative fee plus the difference between your medical plan's administrative fee and the lowest fee.

Medical Rates

PART-TIME EMPLOYEE DEDUCTIONS									
	Part-Time Bi-Weekly Deductions[2] 75% Tier			Part-Time Bi-Weekly Deductions[2] 50% Tier			Part-Time Bi-Weekly Deductions[2] 0% Tier		
	Employee Share	State Share	Total	Employee Share	State Share	Total	Employee Share	State Share	Total
OHIO MED				**OHIO MED**			**OHIO MED**		
Single	$50.44	$145.83	$196.27	$100.64	$97.30	$197.94	$201.27	$0.00	$201.27
Family Minus Spouse	$138.30	$400.61	$538.91	$276.34	$267.15	$543.49	$552.68	$0.00	$552.68
Family Plus Spouse[1]	$144.29	$400.61	$544.90	$282.33	$267.15	$549.48	$558.67	$0.00	$558.67
AETNA				**AETNA**			**AETNA**		
Single	$54.51	$142.13	$196.64	$103.38	$94.83	$198.21	$201.41	$0.00	$201.41
Family Minus Spouse	$149.47	$390.43	$539.90	$283.92	$260.37	$544.29	$553.04	$0.00	$553.04
Family Plus Spouse[1]	$155.47	$390.43	$545.90	$289.91	$260.37	$550.28	$559.03	$0.00	$559.03
PARAMOUNT				**PARAMOUNT**			**PARAMOUNT**		
Single	$48.32	$129.33	$177.65	$92.80	$86.31	$179.11	$182.03	$0.00	$182.03
Family Minus Spouse	$132.45	$355.26	$487.71	$254.80	$236.93	$491.73	$499.75	$0.00	$499.75
Family Plus Spouse[1]	$138.44	$355.26	$493.70	$260.78	$236.93	$497.71	$505.74	$0.00	$505.74
THE HEALTH PLAN				**THE HEALTH PLAN**			**THE HEALTH PLAN**		
Single	$52.70	$145.60	$198.30	$102.77	$97.14	$199.91	$203.19	$0.00	$203.19
Family Minus Spouse	$145.07	$400.00	$545.07	$282.24	$266.75	$548.99	$557.95	$0.00	$557.95
Family Plus Spouse[1]	$151.06	$400.00	$551.06	$288.23	$266.75	$554.98	$563.94	$0.00	$563.94
UNITEDHEALTHCARE				**UNITEDHEALTHCARE**			**UNITEDHEALTHCARE**		
Single	$53.08	$141.29	$194.37	$101.70	$94.27	$195.97	$199.19	$0.00	$199.19
Family Minus Spouse	$145.58	$388.13	$533.71	$279.28	$258.84	$538.12	$546.92	$0.00	$546.92
Family Plus Spouse[1]	$151.57	$388.13	$539.70	$285.27	$258.84	$544.11	$552.90	$0.00	$552.90
ADDITIONAL AMOUNTS FOR EACH HOUSE BILL 1 DEPENDENT				**ADDITIONAL AMOUNTS FOR EACH HOUSE BILL 1 DEPENDENT**			**ADDITIONAL AMOUNTS FOR EACH HOUSE BILL 1 DEPENDENT**		
Ohio Med	$69.57	$0.00	$69.57	$69.57	$0.00	$69.57	$69.57	$0.00	$69.57
Aetna	$69.66	$0.00	$69.66	$69.66	$0.00	$69.66	$69.66	$0.00	$69.66
Paramount	$62.93	$0.00	$62.93	$62.93	$0.00	$62.93	$62.93	$0.00	$62.93
The Health Plan	$70.29	$0.00	$70.29	$70.29	$0.00	$70.29	$70.29	$0.00	$70.29
UnitedHealthCare	$68.87	$0.00	$68.87	$68.87	$0.00	$68.87	$68.87	$0.00	$68.87

1. Family plus spouse rates above include a charge of $5.77 per biweekly pay to cover a spouse.

2. The rates listed above are presented in bi-weekly totals. These rates represent the total amount that will be deducted from each paycheck. They include the following: communication surcharge, mental health charge, and the FY 2010 rate adjustment.

Differences in plan rates are the result of each medical plan's design, claims history and administrative fees. Medical plan administrative fees are a portion of the rates, and the state pays for 85 percent of the lowest administrative fee. If you choose a plan that has a higher administrative fee, you will pay 15 percent of the lowest administrative fee plus the difference between your medical plan's administrative fee and the lowest fee.

Preventive Care Screening - Stay Healthy, Save Money
Preventing disease – and detecting it early if it occurs – is important to living a healthy life. And the better your health, the lower your health care costs are likely to be. One of the most important things you can do for your health and your family's health is to schedule regular checkups and screenings with your primary care physician (PCP).

Your State of Ohio health plan covers the following services with no deductible, no copayment and no coinsurance. Check your health plan for details and information on other services that are available at the normal copayments, coinsurance and deductibles.

One of the most important things you can do for your health and your family's health is to schedule regular checkups and screenings with your primary care physician (PCP).

Free Exams and Screenings	
Procedure	$0 Co-Pay Guideline
Well-baby, well-child exam	Various for birth to 2 years; then annual to age 18
Well-person exam (annual physical)	1/plan year
Hemoglobin, hematocrit, or CBC	1/plan year
Urinalysis	1/plan year
Lipid profile or total and HDL cholesterol	1/plan year
Glucose	1/plan year
Stool for occult blood	1/plan year
Pre-natal office visits	As needed; based on physician's ability to code claims separately from other maternity-related services
GYN exam	1/plan year
Clinical breast exam	1/plan year
Pap	1/plan year
Mammogram	1 baseline between ages 35-39; 1/plan year beginning at age 40
PSA - 1/plan year	Starting at age 40
Flexible sigmoidoscopy	Every 10 years starting at age 50
Colonoscopy	Every 10 years starting at age 50

Free Immunization	
Procedure	$0 Co-Pay Guideline
Hepatitis B (HepB)	Birth; 1-2 months; 6-18 months
Rotavirus (Rota)	2/4/6 months
Diphtheria, tetanus, pertussis (DTaP)	2/4/6/15-18 months; 4-6 years
Tetanus, diptheria, pertussis (Td/Tdap)	11-12 years; Td booster every 10 years, 18 and older
Haemophilus influenzae b (Hib)	2/4/612-15 months
Pneumococcal	2/4/6 months; 12-15 months; annually at age 65 and older; high risk groups
Poliovirus (IPV)	2 and 4 months; 6-18 months; 4-6 years
Influenza	1/plan year
Measles, mumps, rubella (MMR)	12-15 months, then at 4-6 years; adults who lack immunity
Varicella (Chickenpox)	12-15 months; 4-6 years; 2 doses for adult susceptibles
Hepatitis a (HepA)	2 doses b/w 1-2 years
Meningococcal (MCV4)	1 dose between 11-12 years or start of high school or college
Human Papillomavirus (HPV)	3 doses for females age 9 through age 26 years
Zoster (shingles)	1 dose for age 60+

Take Charge! Live Well!

TAKE CHARGE *Live Well*

When you enroll in any of the state's health plans, you and your enrolled spouse are automatically enrolled in the *Take Charge! Live Well!* health and wellness program. Staying healthy is the best strategy for keeping your health care costs at a reasonable level. Each of us can take small steps to improve our health, and that adds up to big differences in your life. *Take Charge! Live Well!* is administered by APS Healthcare. Visit the Web site at ***ohio.gov/tclw***.

$100 Incentive for 2010-2011
Participate in *Take Charge! Live Well!* and earn up to $100 in incentives.
Your spouse can earn another $100.

Earn $50 for taking the Health Assessment between July 1, 2010 and November 30, 2010.

Additional Incentives
July 1, 2010 - June 30, 2011
Health Coaching - $50
Road Show Health Screening - $25
Online Lifestyle Program - $25

Your Pharmacy Benefits

To ensure all state employees receive the highest level of care and customer service, a single pharmacy benefit manager, Catalyst Rx, provides pharmacy benefits for all State of Ohio employees who are enrolled in a state health plan.

Type of Medication	Retail Copayment (30-Day Supply)	90-Day at Retail Copayment (90-Day Supply)	Mail Service Copayment (90-Day Supply)
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

**A multi-source brand-name drug is a brand-name medication that is produced and available through multiple manufacturers and also has a therapeutically equivalent generic alternative available.

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 for generic, preferred brand and non-preferred brand may be less than the flat-dollar copay.

The amount charged to the individual for Non-Preferred, Multi-Source Brand medications may be greater than the Non-Preferred Brand Copay.

Oral and injectable contraceptives, contraceptive patches, Intra-Uterine Devices (IUDs) and diaphragms are covered through your pharmacy benefits.

Pharmacy copays do not apply toward annual out-of-pocket maximum.

Save Money – Use Mail Order

Using mail order for your ongoing maintenance medications is convenient and cost effective. Ordering your prescription medications through the lower-cost mail-order pharmacy is optional for all five medical plans. Copays are 2.5 times the retail copay for a 90-day supply.

90-Day at Retail Program

If you do not want to use the optional mail-order program, you can receive a 90-day supply of medication at your local retail pharmacy at the cost of three times a 30-day supply.

This program offers increased convenience by allowing you to receive a 90-day supply during only one visit to your local participating pharmacy. It also allows you freedom to discuss your prescription with a pharmacist and review possible preferred brand or generic alternatives that might save you even more money.

Mental Health

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

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

Important Note: You will receive additional information about the The Mental Health Parity and Addiction Equity Act of 2008 as the plan designs are finalized.

Exempt Dental, Vision and Basic Life Insurance Benefits

The state pays the full cost for you and your eligible dependents to participate in the dental, vision and basic life plans. Employees are eligible to participate in these programs after one year of continuous state service.

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.

	Plan 1: DeltaPreferred Option			Plan 2: DeltaPremier	
	DeltaPreferred Option Dentist	DeltaPremier Dentist	Non-Delta Dentist	DeltaPremier Dentist	Non-Delta 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 maximum	50% up to $1,500 maximum	50%* up to $1,500 lifetime maximum	50% up to $1,500 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 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.					

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 Web site. Once you have enrolled in a dental plan, visit ***www.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. The following chart compares the two plans:

	VSP Plan		EyeMed Plan	
Service	In-Network	Out-Of-Network	In-Network	Out-Of-Network
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.	You pay $5 copay, then plan pays maximum of $25.
MATERIALS/LENSES Single Vision Lenses Bifocal Lenses Progressive Lenses Trifocal Lenses Lenticular Lenses Polycarbonate Lenses (Available to All)	Plan pays 100% after $15 copay.	You pay $15 copay, then plan pays maximum benefit of: $25 $35 $52 $52 $62 $0	Plan pays 100%.	Plan pays maximum benefit of: $25 $35 $55 $52 $62 $0
FRAMES	Plan pays 100% up to $120 retail.	Plan pays maximum benefit of $18.	Plan pays 100% up to $120 retail.	Plan pays 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 pays maximum of $125 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 pays maximum of $125 plus standard eye exam.

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 Plan or EyeMed Vision Care Plan network. Check with each plan for a complete provider list. See page 19 for contact information.

Union-Represented Employees

Union-represented employees receive some of their benefits, including dental, vision, life and legal plan benefits, through Union Benefits Trust (UBT). The UBT Enrollment Guide will be mailed to union members' homes the week of April 26. The guide includes enrollment/change forms for dental, vision and legal plans. A separate "Supplemental Life Enrollment Kit" from Prudential will arrive during the same period and will include information on supplemental life, rates and an enrollment form.

Exempt Basic Life Insurance
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, is provided at no cost to you, and you are not required to enroll. However you should designate one or more beneficiaries to receive the proceeds of your policy by completing an Exempt Employees of State of Ohio Beneficiary Designation/Change Form available in the forms section of the Benefits Administration Web site at:
www.das.ohio.gov/Divisions/HumanResources/HRDDownloadableForms/tabid/216/Default.aspx

The IRS requires that employees be taxed on the value of employer paid group life insurance coverage over $50,000. This is known as "imputed income". If your salary (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. 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.

Exempt Supplemental Life Insurance
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
- When you purchase supplemental life coverage for the first time, you may elect up to two times your basic annual earnings or $150,000, whichever is less, without providing proof of good health.
- You may elect up to six times your basic annual earnings or $500,000, whichever is less, with acceptable proof of good health. Elections must be made in $10,000 increments.

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 up to 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 should have received an enrollment packet from Prudential. You may also obtain a supplemental life enrollment form on the Benefits Web site at: ***das.ohio.gov/benefits*** and see the Forms section.

Completed enrollment forms must be mailed to Prudential by May 16, 2010.

Supplemental Life Insurance Rate Chart
Monthly Cost per $10,000 of Coverage

Age as of July 1, 2010	Non-Smoker	Smoker
29 and Younger	$0.59	$0.78
30-34	$0.72	$0.78
35-39	$0.82	$1.14
40-44	$1.30	$1.76
45-49	$2.01	$2.92
50-54	$3.13	$4.50
55-59	$5.02	$6.69
60-64	$7.61	$10.26
65-69	$12.26	$18.41
70 and Older	$20.94	$32.95

If you have misplaced your beneficiary form or do not know who is currently designated as your beneficiary, the simplest solution is to complete a new beneficiary form. Beneficiary forms for The Standard and Prudential are available in the forms section of the Benefits Administration Web site at:
www.das.ohio.gov/Divisions/HumanResources/HRDDownloadableForms/tabid/216/Default.aspx

Legal Notices

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 happens:

- 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 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 www.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
Phone: 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 DAS HCM Customer Service Unit 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).

Glossary

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

Coinsurance: The percentage of eligible expenses that the health care plan pays after the annual deductible is met. For example, a 20 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 Share: The portion of the total contribution that you pay through pre-tax payroll deductions for your medical coverage.

HMO: When you enroll in an HMO, benefits are paid only when you visit a provider in the HMO network. No benefits are paid when you visit a provider outside the HMO network, except in the case of a true emergency. HMOs are available to employees in select ZIP codes.

Out-of-pocket Maximum: The cap or maximum amount you pay for eligible out-of-pocket medical 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. Deductible and coinsurance apply to the out-of-pocket maximum. Check with your medical plan to determine if medical plan copays apply toward your out-of-pocket maximum. Prescription copays do not apply to the out-of-pocket maximum.

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 health care.

State Share: The portion of the total contribution the state pays to provide employees with medical coverage.

Health and Other Benefits

MEDICAL

AETNA HMO
1.800.520.4785
www.aetnastateohioemployee.com
Group Number: 619316

MEDICAL MUTUAL
1.800.822.1152
www.mmoh.com
Group Number: 22800001

PARAMOUNT
1.800.462.3589
www.paramounthealthcare.com
Group Number: 030291

THE HEALTH PLAN
1.800.624.6961
www.healthplan.org
Group Number: 01809184

UNITEDHEALTHCARE
1.877.442.6003
www.myuhc.com
Group Number: 702097

PHARMACY

CATALYST RX
1.866.854.8850
www.catalystrx.com

MENTAL HEALTH & SUBSTANCE ABUSE

UNITED BEHAVIORAL HEALTH
1.800.852.1091
www.liveandworkwell.com
Group Number: 00832
Code: 00832

FRINGE BENEFITS MANAGEMENT COMPANY (FBMC)
1.800.342.8017
www.myfbmc.com

AETNA LONG-TERM CARE
1.800.537.8521

TAKE CHARGE! LIVE WELL!

APS HEALTHCARE
1.866.272.5507
stateofohio.apshealthcare.com

OTHER BENEFITS-EXEMPT EMPLOYEES

DELTA DENTAL OF OHIO
1.800.524.0149
www.deltadentaloh.com
9273-0001 (Preferred)
9273-1001 (Premier)

VISION SERVICE PLAN (VSP)
1.800.877.7195
www.vsp.com
Group Number: 12022518

EYEMED VISION CARE
1.866.723.0514
www.eyemedvisioncare.com
Group Number: 9676008

BASIC LIFE
The Standard
1.866.415.9518
www.standard.com/mybenefits/ohio

SUPPLEMENTAL LIFE
PRUDENTIAL LIFE INSURANCE
1.800.778.3827
Group Number: LG-93046

24-HOUR NURSE ADVICE LINE

1.866.272.5507, option 3

OTHER CONTACTS

OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES
DAS HCM Customer Service Unit
614.466.8857
1.800.409.1205
das.ohio.gov/benefits

UNION BENEFITS TRUST
614.508.2255
1.800.228.5088
www.benefitstrust.org

Important Contacts

BARGAINING UNIT CONTACT NUMBERS

Vision Service Plan
1.800.877.7195
www.benefitstrust.org
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

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)

OhioDAS
Service · Support · Solutions
30 E. Broad St., 28th Floor
Columbus, Ohio 43215

LOOK FOR THE SUMMER EDITION:

- Hot News
- Union News
- Flexible Spending Account Open Enrollment
- Benefit Updates