OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES + THE JOINT HEALTH CARE COMMITTEE

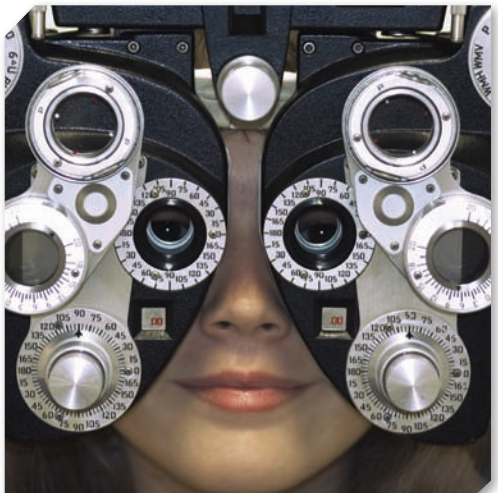
2015

Pathways to my Benefits

OPEN ENROLLMENT

MAY 4 TO 15

2015



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2015 Benefits Overview

Welcome to the 2015 Open Enrollment edition of *Pathways to myBenefits* magazine. The purpose of this edition is to inform you and your family about the State of Ohio's employee health care benefits available this coming benefit year, which begins July 1, 2015.

Eligible employees can elect to enroll or disenroll themselves and/or their dependents in medical, dental, vision and supplemental life insurance coverage during the Open Enrollment period, which is being held Monday, May 4 through Friday, May 15.

If you already are enrolled in benefits, please review your Benefits Summary by logging in to myOhio.gov and clicking the **myBenefits button** to access the benefits information for you as well as your dependents, if applicable. Ensure your dependents still meet the eligibility requirements by visiting das.ohio.gov/EligibilityRequirements. If you do not have any changes to your coverage, no additional action is required.

If you wish to waive your current health coverage, you will need to do so during Open Enrollment.

Important Changes for the Upcoming Benefit Year:

- Pharmacy out-of-pocket maximum cost – a separate out-of-pocket maximum cost will apply to prescription drugs. For details, see the Prescription Drug Web page;
- Oral oncology medications – per Amended Senate Bill 99 of the 130th General Assembly, the maximum copay for oral oncology medications will be $100 for a 30-day supply. For details, see the Prescription Drug Web page;
- Pursuant to the Patient Protection and Affordable Care Act (PPACA), some non-permanent employees may be eligible for medical coverage in the upcoming plan year (July 1, 2015 – June 30, 2016). For details, see the das.ohio.gov/EligibilityRequirements Web page.
- Part-time employees – All permanent and non-permanent part-time employees working an average of 30 or more hours a week (over a 12-month period) will be eligible for the full-time deduction tier.

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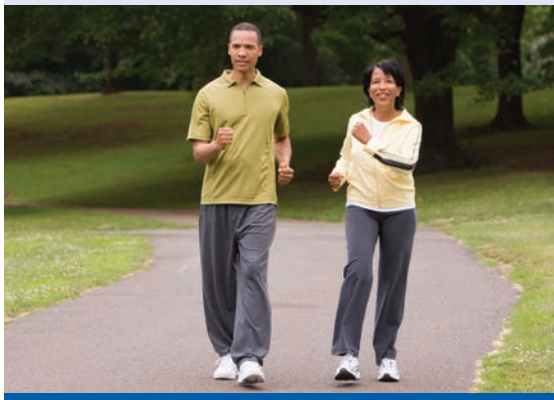

das.ohio.gov/benefits

Benefits Enrollment Instructions

To enroll, disenroll or make changes, please follow the steps below:

1. Review information about available benefits by carefully reading this Open Enrollment edition of *Pathways to myBenefits*. If you have questions, contact your agency benefits representative, human resources office or the Ohio Department of Administrative Services' HR Customer Service desk at 800-409-1205, Option 2.
2. Enroll in medical, dental and vision coverage or make changes to your current coverage or your dependents' current coverage by going online to myOhio.gov or by obtaining a paper form.

A. Online

- Go to myOhio.gov. Enter your State of Ohio User ID and password. If you have forgotten your State of Ohio User ID or password, contact HR Customer Service by calling toll-free, 800-409-1205, or in Columbus, 614-466-8857. Make sure to select Option 1 when prompted;
- Click on **myBenefits** under Self Service Quick Access on the right side of the page;
- The Benefits Summary page will open; review your current benefit information;
- Click on **Enroll in Benefits and make the necessary changes or updates**.
  - Submit your enrollment or changes. All transactions must be completed, submitted and confirmed prior to 7 p.m. Friday, May 15. The system will not accept any entries beginning at 7 p.m. Friday, May 15. Make sure your online changes are correctly submitted by clicking the **SUBMIT** button on the last two pages of the process. At the end, you will receive a confirmation message that can be printed for your records.
    - For detailed instructions on how to enroll or disenroll online, go to: das.ohio.gov/EnrollmentInstructions.
    - Online Open Enrollment is available May 4 through 15, 2015, as follows:

      Weekdays – All day except 7 to 9 p.m.
      Saturdays – All day except 4 to 6 p.m.
      Sundays – All day except 4 p.m. to midnight

B. Paper

- For medical coverage for all eligible employees and dental and vision coverage for exempt employees, obtain a paper State of Ohio Benefit Enrollment/Change Form (ADM 4717) on the Benefits Administration website at: das.ohio.gov/HealthCareForms or from your agency's human resources office.
- For all bargaining unit members, forms to change dental and vision coverage are available at www.benefitstrust.org > Forms & Info.
- Submit your enrollment or changes by giving your completed and signed State of Ohio Benefit Enrollment/Change Form (ADM4717) and/or the Union Benefits Trust Dental & Vision Enrollment Form to your agency's human resources office by 4 p.m. Friday, May 15.

Following Open Enrollment, all eligible employees will receive a confirmation letter in the mail. This letter should arrive in early June. Please review this letter carefully to ensure your enrollment elections have been processed correctly.

IMPORTANT

If you are enrolling for the first time and/or adding new dependents during this Open Enrollment, you must 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. The final deadline to submit all required documentation is July 31.

You will not have another opportunity to enroll yourself or eligible dependents for benefits or make changes to your elections until the next Open Enrollment unless you have a change in status/qualifying event.

Enrollment Eligibility

All eligible employees who currently are not enrolled or who need to make changes to medical, dental, vision or supplemental life can do so during Open Enrollment, held from Monday, May 4 through Friday, May 15.

All choices made during Open Enrollment will become effective July 1, which begins the new benefit year. You will not have another opportunity to enroll yourself or eligible dependents for benefits or make changes to your elections until the next Open Enrollment unless you have a change in status/qualifying event, such as marriage, divorce, or the birth or adoption of a child.

For more information about qualifying events:

1. Go to das.ohio.gov/benefits;
2. Click on the link for the **Change in Status/ Qualifying Events Matrix** along the right navigation pane.

ELIGIBILITY FOR BENEFITS

Employees

- Medical – Most state employees are eligible to enroll in medical coverage (which includes prescription drug, behavioral health and wellness benefits) during Open Enrollment or within 31 days from their hire date. Benefits are effective the first day of the month following the date of hire. Changes made during Open Enrollment are effective July 1. For more information on non-permanent employees becoming newly eligible for coverage pursuant to the PPACA, please see the das.ohio.gov/EligibilityRequirements Web page.
- Dental and Vision – Permanent exempt and union-represented employees are eligible to enroll in dental and vision coverage effective the first day of the month after completing one full year of continuous state service or thereafter during Open Enrollment.
- Basic Life – Permanent exempt and union-represented employees are eligible for basic life coverage after completing one full year of continuous state service. Enrollment is automatic. The basic life insurance benefit for union-represented employees is provided through Prudential. The exempt employees' basic life insurance benefit is provided through Minnesota Life.
- Supplemental Life – Permanent exempt and union-represented employees are eligible for coverage on their date of hire and have 90 days to enroll.[1] Union-represented employees also may enroll or make changes during Open Enrollment. The supplemental life insurance benefit for union-represented employees is provided through Prudential. The exempt employees' supplemental life insurance benefit is provided through Minnesota Life.

[1] Certain new enrollments or increases are subject to evidence of insurability and may delay the effective date of coverage.

Dependents

To view the detailed eligibility and enrollment requirements for all dependents, visit: das.ohio.gov/EligibilityRequirements.

Note: To ensure that dependent documentation is processed prior to July 1, it is recommended that employees submit all required eligibility documentation for dependents to your agency benefits specialist by June 3. The final deadline to submit all required documentation is July 31.

Due to various federal and state regulations regarding dependent children, including Ohio House Bill 1 (HB1) and federal health care reform, please refer to the chart on Page 6 for more guidance.

Did you know?

In the event of a qualifying life event, such as a marriage, divorce, birth, adoption of a child or a child reaching the age of ineligibility, you have 31 days to add or remove dependents to or from coverage. If you wait longer than 31 days, you will have to wait until the next Open Enrollment period to add the dependent. If you fail to remove a dependent from coverage within 31 days of a qualifying event, you may be responsible for health care expenses incurred by the ineligible dependent.

It is your responsibility to contact your agency benefits specialist or human resources office when one of your enrolled dependents is or becomes ineligible for benefits coverage.

PLEASE NOTE: The material in this publication is for informational purposes. It is intended only to highlight the main benefits, eligibility policies and coverage information for State of Ohio employees and their dependents. 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. To locate the plan documents on the Benefits Administration website, das.ohio.gov/benefits, click on **Medical** located in the right navigation pane under Benefits.

Eligibility for Benefits

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
Children ages 23 - 25	Coverage available for eligible dependents[1]	No coverage available	No coverage available	Coverage available for eligible dependents
Children ages 26 - 27	Coverage available for eligible dependents[1]	No coverage available	No coverage available	No coverage available

[1] View detailed eligibility and documentation requirements at: das.ohio.gov/EligibilityRequirements.

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 COBRA (continuation coverage) if you notify your agency benefits specialist (or human resources office) within 60 days after the qualifying event.

Enrollment or continuation of an ineligible dependent may result in loss of benefits, disciplinary action and/or repayment of claims. If you fail to remove a dependent from coverage within 31 days of a qualifying event, you may be responsible for health care expenses incurred by the ineligible dependent.

Medical Benefits

The State of Ohio contracts with Medical Mutual of Ohio and UnitedHealthcare to serve as the third-party administrators for the Ohio Med Preferred Provider Organization (PPO) plan. Under this plan, employees have access to both network and non-network providers.

Medical Mutual and UnitedHealthcare each serve specific regions in Ohio based on home ZIP codes. You are assigned your third-party administrator based on the first three digits of your home ZIP code. Review the chart below that features the ZIP code breakdown by plan administrator. Employees with home ZIP codes outside Ohio are automatically enrolled in UnitedHealthcare.

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	

For deduction information, see the charts on Page 8.

When you are enrolled in medical coverage, you automatically gain prescription drug, behavioral health and wellness benefits.

Copayments, deductibles and co-insurance are combined with your behavioral health plan. If you receive medical services prior to meeting your 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.

TO OBTAIN INFORMATION FROM YOUR THIRD-PARTY ADMINISTRATOR:

If you would like to receive information from your assigned third-party administrator – either Medical Mutual or UnitedHealthcare, refer to the Health and Other Benefits Contacts information on Page 16. You can visit your third-party administrator's website to download and print the information or call their customer service unit to request that it be mailed to you.

SAVE MONEY: USE BENEFITS WISELY

All of 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 third-party administrator does not pay for your claims. Rather, Medical Mutual and UnitedHealthcare review claims and process payments, and are paid an administrative fee. When the amount of claims is greater than the amount of the contributions from employees and agencies, your medical costs go up.

It is up to each of us to use our benefits wisely. We can all do our part by making wellness a priority in our lives, evaluating our options when we need care and avoiding unnecessary visits.

Ohio Med PPO

	OUT-OF-POCKET COSTS
Annual Deductible	Network: $200 single, $400 family; out-of-network: $400 single, $800 family. (Combined with behavioral health.)
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 [3]	Network: $1,500 single, $3,000 family; out-of-network: $3,000 single, $6,000 family.[2] (Combined with behavioral health.)
BENEFIT/SERVICE	**COVERAGE LEVELS**
Chiropractic Care	• Covered at 80% in-network; 60% out-of-network. • Unlimited visits.
Diagnostic, X-Ray and Lab Services	• Covered at 80% in-network; 60% out-of-network.
Durable Medical Equipment	• Covered at 80% in-network; 60% out-of-network.
Emergency Room	• Covered at 80%; $75 copay, which is waived if patient is admitted as inpatient; 60% out-of-network for non-emergency.
Hearing Loss (Accidental, Injury or Illness)	• Covered at 80% in-network; 60% out-of-network. • Exams and follow-ups are included in coverage.
Home Health Care	• Covered at 80% in-network; 60% out-of-network; limit of 180 days.
Hospice Services	• Covered at 100% with no copay, time or dollar limitations for both in- and out-of-network.
Immunizations	• Most are covered at 100% in-network; 60% out-of-network.
Infertility Testing	• Covered at 80% after $20 copay, for in-network; 60% after $30 copay out-of-network. • Coverage includes testing only.
Inpatient and Outpatient Services	• Covered at 80% in-network; 60% out-of-network.
Maternity - Delivery	• Covered at 80% in-network; 60% out-of-network.
Maternity - Prenatal/ Postpartum Care	• Prenatal Care: Office visits covered at 100% when billed separately from delivery; tests/procedures covered at 80% in-network; 60% out-of-network. Postpartum Care: breast-feeding support and counseling (including lactation classes), and supplies (including breast pump rental) covered at 100%.
Physical, Occupational and Speech Therapy	• Covered at 80% in-network; 60% out-of-network. • Unlimited visits (review required). • Includes coverage for Autism Spectrum Disorder.
Preventive Exams and Screenings	• Most preventive care covered at 100% in-network; 60% out-of-network. • Age restrictions may apply.
Skilled Nursing Facility	• Covered at 80%; 180-day limit, additional days covered at 60%, for both in- and out-of-network.
Urgent Care	• $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 PPO's contracted allowable amount and you pay any remaining balance.
[2] If your out-of-network charge is greater than the Ohio Med PPO contracted allowable amount, your out-of-pocket costs will be more.
[3] For prescription drug out-of-pocket cost information, see the Prescription Drug Web page.

FULL-TIME EMPLOYEE MEDICAL DEDUCTIONS

	FULL-TIME / BIWEEKLY PAID EMPLOYEE DEDUCTIONS[1]			FULL-TIME / MONTHLY PAID EMPLOYEE DEDUCTIONS[1]		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$36.22	$204.17	$240.39	$78.48	$442.39	$520.87
Family Minus Spouse	$99.07	$560.31	$659.38	$214.65	$1,214.00	$1,428.65
Family Plus Spouse[2]	$104.84	$560.31	$665.15	$227.15	$1,214.00	$1,441.15

[1] These rates represent the total amount that will be deducted from your paycheck.

[2] Family Plus Spouse rates above include a charge of $12.50 per month to cover a spouse.

PART-TIME EMPLOYEE MEDICAL DEDUCTIONS

	PART-TIME BIWEEKLY DEDUCTIONS[1] 50% TIER			PART-TIME BIWEEKLY DEDUCTIONS[1] 0% TIER		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$120.19	$120.20	$240.39	$240.39	$0.00	$240.39
Family Minus Spouse	$329.69	$329.69	$659.38	$659.38	$0.00	$659.38
Family Plus Spouse[2]	$335.46	$329.69	$665.15	$665.15	$0.00	$665.15

[1] These rates represent the total amount that will be deducted from your paycheck.

[2] Family Plus Spouse rates above include a charge of $12.50 per month to cover a spouse.

ADDITIONAL BIWEEKLY AMOUNT FOR EACH HB1 DEPENDENT (FOR ALL ENROLLED EMPLOYEES)

	Employee Share	State Share	Total
Ohio Med PPO	$103.81	$0.00	$103.81

ADDITIONAL MONTHLY AMOUNT FOR EACH HB1 DEPENDENT (FOR ALL ENROLLED EMPLOYEES)

	Employee Share	State Share	Total
Ohio Med PPO	$224.92	$0.00	$224.92

Preventive Care

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.

Your State of Ohio medical plan offers the following services with no deductible, no copayment and no coinsurance for network providers. Other services are available for the normal copayment, coinsurance and deductible amounts.

FREE EXAMS AND SCREENINGS	
Clinical breast exam	1/plan year
Colonoscopy	Every 10 years starting at age 50
Flexible sigmoidoscopy	Every 10 years starting at age 50
Glucose	1/plan year
Gynecological Exam	1/plan year
Hemoglobin, hematocrit or CBC	1/plan year
Lipid profile or total and HDL cholesterol	1/plan year
Mammogram	1 routine and 1 medically necessary/plan year
Pre-natal office visits	As needed; based on physician's ability to code claims separately from other maternity-related services
Prostate-specific Antigen (PSA)	1/plan year starting at age 40
Stool for occult blood	1/plan year
Urinalysis	1/plan year
Well-baby, well-child exam	Various for birth to 2 years; then annual to age 21
Well-person exam (annual physical)	1/plan year

FREE IMMUNIZATIONS	
Diphtheria, tetanus, pertussis (DTap)	2/4/6/15-18 months; 4-6 years
Haemophilus influenza b (Hib)	2/4/6/12-15 months
Hepatitis A (HepA)	2 doses between 1-2 years
Hepatitis B (HepB)	Birth; 1-2 months; 6-18 months
Human Papillomavirus (HPV)	3 doses for 9-26 years
Influenza	1/plan year
Measles, mumps, rubella (MMR)	12-15 months, then at 4-6 years; adults who lack immunity
Meningococcal (MCV4)	1 dose between 11-12 years or start of high school or college
Pneumococcal	2/4/6 months; 12-15 months; annually at age 65 and older; high risk groups
Poliovirus (IPEV)	2 and 4 months; 6-18 months; 4-6 years
Rotavirus (Rota)	2/4/6 months
Tetanus, diphtheria, pertussis (Td/Tdap)	11-12 years; Td booster every 10 years, 18 and older
Varicella (Chickenpox)	12-15 months; 4-6 years; 2 doses for susceptible adults
Zoster (shingles)	1 dose for age 19 +

Note: This is not an all-inclusive list. Please refer to das.ohio.gov/Divisions/HumanResources/BenefitsAdministration/Medical for more information about preventive care services.

Prescription Drug

Catamaran provides prescription drug benefits for State of Ohio employees who are enrolled in the Ohio Med PPO Plan.

Diabetes Management Program

Members are eligible for free diabetic supplies and medication if they have had a hemoglobin A1C test within the past 12 months of being a member of the Ohio Med PPO.

Pharmacy website offers online tracking, tools

The website for Catamaran, myCatamaranRx.com, is a private, secure website designed just for you. All of your pharmacy plan information is available at your fingertips 24/7.

Easy access to the Catamaran website allows you to:

- Compare mail-order prices and prices at local pharmacies;
- Find your lowest copay;
- Locate your pharmacy and get driving directions;
- Manage your mail-order prescriptions, including options to request a refill or track an order; and
- Learn more about your prescription drugs.

Visit myCatamaranRx.com today. You will need your pharmacy member ID number on your Catamaran card to log in. The number begins with the letter "A."

For questions, contact Catamaran at 866-854-8850.

Specialty drug management program

Some specialized medications for serious medical conditions such as cancer, cystic fibrosis and rheumatoid arthritis must be obtained from the specialty pharmacy Briova and can only be filled for 30 days or less. Your order may be shipped to your home or workplace. A description of the program and a list of specialty medications are available on the Benefits Administration website at das.ohio.gov/prescriptiondrug under the **Specialty Drug List**.

Not all drugs are covered

Some drugs require the use of alternative medications before being approved. This is known as "step therapy." Examples include medications used for heartburn, glaucoma, multiple sclerosis, diabetes, asthma, elevated triglycerides, migraines, osteoporosis, nasal allergies, sleep disturbances and high blood pressure as well as 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 in advance by mail.

A description of the program and a list of medications are on the Benefits Administration website at das.ohio.gov/prescriptiondrug under "Prescription Drug Updates."

New For 2015

Beginning July 1, 2015, a separate out-of-pocket maximum for prescription drugs will apply. For details, see the Prescription Drug Web page. All of your prescription copay amounts will count toward the pharmacy out-of-pocket maximum. Once the limit is reached, any future prescriptions you receive will have a $0 copay. Like the medical out-of-pocket maximum, this limit will reset at the beginning of every benefit year on July 1. This limit only applies to prescriptions and is not combined with the medical/behavioral health out-of-pocket maximum.

COPAYMENT COSTS

TYPE OF MEDICATION	30-DAY SUPPLY AT RETAIL COPAYMENT	30-DAY SUPPLY SPECIALTY COPAYMENT	90-DAY SUPPLY AT RETAIL COPAYMENT	90-DAY SUPPLY AT MAIL-ORDER COPAYMENT
Generic	$10	$10	$30	$25
Preferred Brand-Name	$25	$25	$75	$62.50
Non-Preferred Brand-Name, Generic Unavailable	$50	$50	$150	$125
Non-Preferred Brand-Name, Generic Available	$50 plus the difference between the cost of the brand-name and generic drug	$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/behavioral health plan deductibles and the annual out-of-pocket maximum.

The maximum copay for oral oncology medications will be $100 for a 30-day supply. For details, see the Prescription Drug Web page.

Behavioral Health

HELP AVAILABLE 24/7

Specialized behavioral health and substance abuse services are provided under a single program available to all enrolled employees and their dependents in the state's medical plan. This program, administered by Optum Behavioral Solutions, provides 24-hours-a-day, seven-days-a-week phone assessment and referral services for a variety of behavioral health issues, such as:

- Alcohol;
- Anger management;
- Anxiety;
- Chemical dependency;
- Compulsive disorders;
- Depression;
- Marital and family issues;
- Serious mental illness; and
- Stress.

Copayments, deductibles and co-insurance are combined with your medical plan. If you receive behavioral health services prior to meeting your 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.

Benefits

All enrolled employees and their dependents have access to both in-network and out-of-network behavioral health benefits. However, you will pay more if you do not use a network of participating providers and facilities. See the chart on this page for further details.

Support Services

Also, the State of Ohio offers support services through the Ohio Employee Assistance Program (OEAP) for various behavioral health issues, which includes behavioral health referrals and consultations for employees and their dependents. Other services include training, critical incident stress management, organizational transition interventions and mediation.

BEHAVIORAL HEALTH BENEFIT PLAN	
Copayments	
Outpatient office visit in-network	$20
Outpatient office visit out-of-network	$30; Balance billing applies
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 other services
Outpatient out-of-network	60% of fee schedule after copayment; Balance billing applies
Inpatient in-network	80% after deductible
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

Make Wellness Your Priority

LET *TAKE CHARGE! LIVE WELL!* BE YOUR GUIDE

Your health and wellness is important to us. The State of Ohio offers a robust and comprehensive health and wellness program called *Take Charge! Live Well!*

Take Charge! Live Well! provides the tools, guidance and resources you need to be healthier, happier and more productive, while reducing health care costs.

On a personal level, the benefits of *Take Charge! Live Well!* include:

- Biometric screenings;
- Well-Being Assessments;
- Health coaching;
- Rewards for taking steps to improve your health;
- 24-hour Nurse Advice Line;
- Flu vaccinations;
- Health and wellness fairs;
- Weight-loss challenges;
- Activities challenges;
- A website full of resources, ohio.gov/tclw;
- Online tracking of wellness activities; and
- On-site wellness ambassadors to provide information and answer questions.

Specific programs include:

- Tobacco cessation; and
- Diabetes prevention.

At an enterprise level, *Take Charge! Live Well!* is designed to:

- Offer preventive care tools and resources to its enrolled members;
- Increase productivity;
- Encourage engagement among employees;
- Improve retention; and
- Contain or reduce health care costs by improving health.

Take Charge! Live Well! supports you in your effort to be your healthiest by helping you identify risks and improve your health.

Employees active in *Take Charge! Live Well!* have expressed that they appreciate the blend of an educational and motivational approach to health and wellness.

For full details, visit the *Take Charge! Live Well!* website at: ohio.gov/tclw.

PATHWAYS TO WELLNESS

Step 1: ASSESS YOUR HEALTH

- Complete your biometric screening through an on-site screening or through your physician: **Earn $75**
- Complete your Well-Being Assessment: **Earn $50**

BONUS: Submit BOTH by Nov. 30, 2015: **Earn another $25**

Step 2: TAKE ACTION – It's Your Choice!

- Complete the Coaching Pathway; OR
- Complete the Online Pathway

Earn $200

Reward cards are considered taxable compensation. The taxes on the amount of your incentive will be deducted from your paycheck.

For more detailed information about rewards and the *Take Charge! Live Well!* program, go to the *Take Charge! Live Well!* website at ohio.gov/tclw and click on the **Program Guide** button.

Healthways Website Updates Scheduled

Healthways will be performing annual system updates from July 1 through 14. During this time, the Healthways website will not be accessible.

FOR EXEMPT EMPLOYEES

Life Insurance

ENJOY PEACE OF MIND

The State of Ohio pays the cost for all eligible exempt employees to participate in the basic life plan. Eligible exempt employees are automatically enrolled in the basic life plan after one year of continuous state service.

Exempt Basic Life Insurance

The State of Ohio provides and pays for basic life insurance coverage, including an accidental death and dismemberment benefit for work-related injuries, to all eligible exempt employees who have at least one year of continuous state service. This benefit – equal to your annualized rate of pay rounded to the next highest $1,000 – is provided to you at no cost.

The Internal Revenue Service (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 annualized rate of pay (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 the imputed income rate chart below.

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

Beneficiary Forms

You may designate one or more beneficiaries for your basic and supplemental life benefits by visiting the Minnesota Life website at lifebenefits.com. For logon instructions, see Page 16 under Life Insurance for exempt employees. Or you may submit a beneficiary form by mail to Minnesota Life. This form is available in the forms section of the DAS Benefits Administration website, located at das.ohio.gov/HealthPlanForms. Your beneficiary elections will apply to both your basic and supplemental life insurance benefits.

Exempt Supplemental Life Insurance

Exempt employees are eligible to purchase supplemental life insurance coverage, provided by Minnesota Life. This coverage is at your own cost, and can be purchased within 90 days of employment with no waiting period. When you enroll for 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. See Page 16 for plan contact information and initial logon credentials.

For Yourself

At Open Enrollment, if you do not already have supplemental life coverage, you may purchase up to the lesser of two times your annualized earnings or $150,000 without evidence of insurability. If you have existing coverage, you may increase coverage by up to the lesser of two times your annualized earnings or $150,000 without evidence of insurability.

The maximum amount of coverage available is the lesser of eight times your annualized earnings or $600,000. If your coverage election exceeds the non-medical limits described above, evidence of insurability will be required. Coverage above the non-medical limits will become effective once evidence of insurability is approved by Minnesota Life. Outside of open enrollment, supplemental life coverage may not be increased, without a qualifying life event. In the event of a qualifying life event, you must submit your request within 31 days of the associated life event.

For Your Spouse

You may 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 evidence of insurability.

For Your Dependent Children

You may purchase $7,000 of life coverage for each of your eligible dependent children younger than age 26 at a rate of $0.82 cents per month, regardless of how many children you cover. You are responsible for dropping your dependent's coverage when your child reaches age 26.

Cancelling or Reducing Coverage

You may cancel or reduce your employee or dependent supplemental life insurance coverage at any time throughout the year by submitting a written request to Minnesota Life. Coverage will be cancelled or reduced effective the first of the month after which your request is received and processed by Minnesota Life.

FOR EXEMPT EMPLOYEES

Dental and Vision

The State of Ohio pays the full cost for you and your eligible dependents (children younger than age 23[1]) to participate in the dental and vision plans. Exempt employees are eligible to participate in these plans effective the first day of the month after completing one year of continuous state service.

Delta Dental PPO

Dental coverage is offered through the Delta Dental PPO plan, offered through Delta Dental of Ohio. You can go to any licensed dentist of your choice and receive benefits, but you typically will pay less when you go to an in-network dentist.

Your out-of-pocket expenses will vary depending on the participation status of your dentist. Your out-of-pocket costs are likely to be lower if you go to a dentist who participates in one of the Delta Dental networks. For most covered services, Delta Dental pays a higher percentage if you go to a dentist in its PPO network over its Premier network. Delta pays the least for out-of-network dentists.

To find the names of participating Delta Dental dentists near you, visit or call:

deltadentaloh.com
800-524-0149
Group Number: 9273-0001

Print Your Delta Dental Card Online

If you would like a card to present to your dentist, you may print a card from Delta Dental's website. After you are enrolled in the dental plan, visit deltadentaloh.com and click on **Consumer Toolkit**.

Complete the login process and click on **Print ID Card**. If you are enrolling in the plan for the first time, please wait until July 1 to access the dental site.

Vision Service Plan

Vision coverage is offered through Vision Service Plan (VSP). The VSP Choice network encompasses a large number of providers. If you use a non-network provider, out-of-network charges will apply.

To find the names of participating VSP vision providers near you, visit or call:

vsp.com
800-877-7195
Group Number: 12022518

Print Your VSP Card Online

If you would like an enrollment card to present to your vision provider, you may print a card through the VSP website. After you are enrolled in the vision plan, visit vsp.com, complete the login process and click on **My Member Vision Card**. If you are enrolling in the vision plan for the first time, wait until July 1 to access the site.

See Page 15 to view the in-network and out-of-network benefits for the dental and vision plans.

[1] View detailed eligibility and documentation requirements at: das.ohio.gov/EligibilityRequirements.

UNION BENEFITS TRUST

For Union-Represented Employees

Union-represented employees receive dental, vision, life and legal plan benefits through Union Benefits Trust (UBT).

The UBT Enrollment Guide will be mailed to union members' homes. The guide includes enrollment/change forms for dental, vision and legal plans. For supplemental life insurance, a separate mailing from Prudential will arrive during the same period. For more information, please visit benefitstrust.org.

DELTA DENTAL PLAN FOR EXEMPT EMPLOYEES

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Delta Dental Dentist*
Annual Maximum	$1,500	$1,500	$1,500*
Diagnostic and Preventive Services	100%	100%	100%*
Basic Restorative Services (e.g., fillings)	100%	65%	65%*
Major Restorative Services (e.g., crowns, bridges)	60%	50%	50%*
Orthodontia	50% up to $1,500 lifetime maximum	50% up to $1,500 lifetime maximum	50% up to $1,500* lifetime maximum

Deductible – $25 deductible per person total per benefit year. The deductible does not apply to diagnostic and preventive services, emergency palliative treatment, X-rays, periodontal maintenance (cleaning) and orthodontic services.

There is a separate $1,000 lifetime maximum on dental implants.

*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.

VISION SERVICE PLAN (VSP) FOR EXEMPT EMPLOYEES

Service	In-Network	Out-Of-Network
Routine Exam/Frame/ Lens Frequency	1 every 12 months	
Routine Exam/ Professional Fees	Plan pays 100% after $10 copay.	You pay $10 copay, then plan pays maximum of $25.
FRAMES	Plan pays 100% up to $120 retail.	Plan pays maximum benefit of $18.
MATERIALS/LENSES Single Vision Lenses Bifocal Lenses Progressive Lenses Trifocal Lenses Lenticular Lenses Polycarbonate Lenses	Plan pays 100% after $15 copay.	You pay $15 copay, then plan pays maximum benefit of: $25 $35 $52 $52 $62 $0
CONTACT LENSES Elective (Instead of Lenses and Frames)	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.

Health and Other Benefits Contacts

ALL EMPLOYEES

Medical
Medical Mutual of Ohio
800-822-1152
medmutualstateohioemployee.com
Group Number: 228000

UnitedHealthcare
877-440-5977
welcometouhc.com/ohio
Group Number: 702097

Prescription Drug
Catamaran
866-854-8850
MyCatamaranRx.com
Rx Group Number: STOH

Behavioral Health and Substance Abuse
Optum Behavioral Solutions
800-852-1091
liveandworkwell.com
Website Access Code: 00832

Ohio Employee Assistance Program
800-221-6327
ohio.gov/eap

Take Charge! Live Well!
Healthways
866-556-2288
ohio.gov/tclw
Click the **Healthways website** button.

24-Hour Nurse Advice Line
Healthways
866-556-2288, Option 1

Flexible Spending Accounts and Commuter Choice
WageWorks
855-428-0446
wageworks.com

EXEMPT EMPLOYEES ONLY

Dental
Delta Dental of Ohio
800-524-0149
deltadentaloh.com
Delta Dental PPO
Group Number: 9273-0001

Vision
Vision Service Plan (VSP)
800-877-7195
vsp.com
Group Number: 12022518

Life Insurance
Basic Life Insurance and Supplemental Life Insurance
Minnesota Life
866-293-6047
lifebenefits.com
Group Number: 34301

Initial logon credentials:
The initial user ID is "**OH**" plus your State of Ohio User ID. The initial password is your date of birth (MMDDYYYY) plus the last four digits of your Social Security Number.

UNION-REPRESENTED EMPLOYEES ONLY

Union Benefits Trust
614-508-2255
800-228-5088
benefitstrust.org

The websites of the Union Benefits Trust (UBT) vendors listed below can be accessed through the UBT website.

Dental
Delta Dental of Ohio
877-334-5008
Group Number: 1009

Vision
Vision Service Plan (VSP)
800-877-7195
Group Number: 12022914

EyeMed Vision Care
866-723-0514
Group Number: 9674813

Life Insurance
Prudential Life Insurance
800-778-3827
Group Number: LG-01049

Work/Life Program
Working Solutions Program
800-358-8515
Group Number: 4718

Legal Services
Hyatt Legal Services
800-821-6400
Group Number: 4900010

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

- Group Number
- State of Ohio User ID
- Explanation of Benefits if call is regarding a claim.

Ohio Department of Administrative Services
HR Customer Service
614-466-8857 (option 2) / 800-409-1205 (option 2)
HRCustomerService@das.ohio.gov
das.ohio.gov/benefits

State of Ohio Employee Health Plans
30 E. Broad St., 27th Floor, Columbus, Ohio 43215

NOTICE OF PRIVACY PRACTICES

Effective April 1, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes the privacy practices of the State of Ohio's self-funded medical plans, prescription drug plan, behavioral health plan, population health management plan, dental plans, vision plans, flexible spending account (but not dependent care flexible spending account) which are administered by the State of Ohio, Department of Administrative Services, Office of Benefits Administration Services (collectively "the Plan"). The Plan is required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information (PHI), and to provide individuals with notice of the legal duties and privacy practices with respect to protected health information and to abide by the terms of the notice currently in effect.

POSITION ON PRIVACY

The Plan is committed to maintaining the privacy of its enrolled persons. As part of your participation in the health plans, the Plan and its business associates (whom we use to administer and deliver health care services) receive health information through the operation and administration of the plans. PHI refers to any information, transmitted or maintained in any form or medium, which the Plan creates or receives that relates to your physical or mental health, the delivery of health care services to you or payment for health care services that identifies you or could reasonably be used to identify you. PHI and other Plan records are maintained in compliance with applicable State and federal laws.

If you have questions about this notice, please contact the Plan's HIPAA Privacy Contact listed below.

HOW THE PLAN MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Plan may only use or disclose your medical information as described in this notice. Not every authorized use or disclosure in each category is listed, however all permitted uses and disclosures fall into one of these general categories

1. Uses and Disclosures of Your PHI For Treatment, Payment, and Health Care Operations

   For Treatment. The Plan may make requests, uses, and disclosures of your PHI as necessary for treatment purposes. For example, the Plan may make disclosures to your health plan regarding eligibility, or make disclosures to health care professionals involved in your care.

   For Payment. The Plan may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, the Plan may use information regarding your medical procedures and treatment so the third party administrator can process and pay claims. The Plan may also disclose your PHI for the payment purposes of a health care provider or a health plan.

   For Health Care Operations Purposes. The Plan may use and disclose your PHI as necessary for health care operations. For example, Health Care Operations include, but are not limited to, use and disclosures: by health plan of PHI to the Plan for administration of the health plans; for quality assessment of the plans through the distribution and analysis of satisfaction surveys; in connection with the performance of disease management functions; and for general administrative activities, including customer service, cost management, data management, communications, claims and operational audits, and legal services. In addition, a health plan may send you information based on your own health information to inform you of possible treatment options or alternatives that may be available to you. The Plan may also combine your health information with that of other enrolled persons to evaluate the coverage provided and the quality of care received.

2. Other Uses and Disclosures of PHI for Which Your Authorization is Not Required

   In limited instances, the law allows the Plan to use and disclose your PHI without your authorization in the following situations:

   A. As Required By Law. The Plan will use or disclose your PHI when required by federal, state or local law.

   B. Family and Individuals Involved in Your Care. The Plan may release medical information about you to a family member or friend who is involved in your medical care. The Plan may request that your family members verify their identity and demonstrate they are acting on your behalf.

   C. To Avert a Serious Threat to Health or Safety. The Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public.

   D. Public Health Activities. The Plan may disclose medical information about you for public health activities including activities related to preventing and controlling disease or, when required by law, to notify public authorities concerning cases of abuse or neglect.

   E. Victims of Abuse, Neglect, or Domestic Violence. The Plan may disclose medical information to a government authority, including a social service or protective agency if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence.

   F. Health Oversight Activities. The Plan may disclose medical information to a health oversight agency if authorized by law in order to monitor the overall health care system, the conduct of government programs, and compliance with civil rights laws.

   G. Lawsuits/Legal Disputes. The Plan may disclose medical information about you in the course of an administrative or judicial proceeding, such as in response to a subpoena, discovery request, warrant, or a lawful court order.

H. Law Enforcement Purposes. The Plan may release medical information to law enforcement officials for law enforcement purposes including investigation of a crime or to identify or locate a suspect, fugitive, material witness or missing person.

I. Specialized Government Functions. The Plan may release medical information to authorized federal officials for the purposes of intelligence, counterintelligence, and other national security activities authorized by law.

J. Military. If you are a member of the armed forces, the Plan may release medical information about you as required by military command authorities.

K. Organ, Eye and Tissue Donation. If you are an organ donor, the Plan may release information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

L. Workers' Compensation. The Plan may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

M. Coroners, Medical Examiners, and Funeral Directors. The Plan may release medical information to a coroner or medical examiner to, for example, identify a deceased person or determine the cause of death. The Plan may also release medical information about patients to funeral directors as necessary to carry out their duties.

N. Business Associates. The State contracts with parties who provide necessary services for the operation of its plans. For example, the Plan is assisted in its operations by third party administrators. These persons who assist the Plan are called business associates. At times, the Plan may disclose PHI so they can provide services. The Plan will require that any business associates who receive PHI safeguard the privacy of that information.

O. Disclosure to You. The Plan may disclose your medical information to you.

3. Other Uses and Disclosures of PHI Requiring Your Written Authorization

In all situations other than those described previously, the Plan will ask for your written authorization before using or disclosing your PHI. For example, (except as required or permitted by law) the Plan will not use or disclose psychotherapy notes or sell your medical information without obtaining your prior written authorization. If you have provided authorization, you may revoke it in writing at any time, unless the Plan has already disclosed the information.

4. Changes To Existing Laws

Certain provisions of Ohio law may impose greater restrictions on uses and/or disclosures of PHI, or otherwise be more stringent than federal rules protecting the privacy of PHI. If such provisions of Ohio law apply to a use or disclosure of PHI or under other circumstances described in this notice, the Plan must comply with those provisions.

Your Legal Rights

Federal privacy regulations provide you the following rights associated with your medical information:

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. (For example, you could ask that the Plan not disclose or use information about a certain medical treatment you received.) **The Plan is not required to agree to your request**. To request restrictions on the use or disclosure of your PHI, you must make your request in writing to the Plan's HIPAA Privacy Contact listed below. In your request, you must explain: (1) what PHI you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and, (3) to whom you want the limits to apply (for example, your spouse).

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at a specific phone number or address. To request confidential communications, you must make your request in writing to the Plan's HIPAA Privacy Contact listed below. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. After the Plan receives your request, the information may be forwarded to your health plan. As a result, additional reasonable information may be required from you by your plan to process the request.

Right to Inspect and Copy Your Information. You have the right, in most cases, to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Plan's HIPAA Privacy Contact listed below. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing, or other unusual supplies associated with your request. Under Ohio and federal law, the Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Request an Amendment. If you feel that medical information about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Plan's HIPAA Privacy Contact listed below. You must provide reasons that support your request. If the Plan denies your request for any reason under state or federal law, the Plan will permit you to submit a written statement of disagreement to be kept with your PHI. The Plan may reasonably limit the length of such statement of disagreement.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures the Plan has made of medical information about you. This accounting will not include

many routine disclosures including, but not limited to, those made to you or pursuant to your authorization, those made for treatment, payment and operations purposes as discussed above, those made for national security and intelligence purposes, and those made to law enforcement in compliance with law.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan's HIPAA Privacy Contact listed below. Your request must state the time period that may not be longer than six (6) years prior to the date on which the accounting is requested. Your request should indicate in what form you want the list (paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice even if you have received it electronically. You may make your request to the Plan's HIPAA Privacy Contact below.

Right to Breach Notification. You have the right to notification if a breach of your unsecured PHI has occurred.

This Notice Is Subject To Change

The Plan reserves the right to change the terms of this notice and its privacy practices at any time. If such a change is made, the new terms and policies will be effective for all of the information that the Plan has about you as well as any information it may hold about you in the future, and will be posted at das.ohio.gov and may be provided by mail if required. If you want to ensure you have the latest version of this notice, you may contact the Plan's HIPAA Privacy Contact listed below.

Whom to Contact

If you believe your privacy rights have been violated, you may file a complaint with the Plan's HIPAA Privacy Contact listed below or with the Secretary of the Department of Health and Human Services.

- To file a complaint with the Plan, mail your written comments to the address below.
- To file a complaint with the Secretary of the U.S. Department of Health and Human Services, contact the Office of Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601.

Complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

Questions regarding this Notice may be directed to the Plan's HIPAA Privacy Contact:

DAS -- HIPAA Privacy Contact
30 East Broad St., 27th Floor
Columbus, Ohio 43215
614-466-6205; email: gregory.pawlack@das.ohio.gov

NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE

WHAT IS COBRA CONTINUATION COVERAGE?

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. You, your spouse and dependent children, if any, should all take the time to read the entire notice carefully.

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 either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- 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 happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- 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 hours of employment are reduced;
- 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."

*If a covered child of the employee is enrolled in the plan pursuant to a qualified medical child support order (QMCSO) during the employee's period of employment, he or she is entitled to the same rights under COBRA as if he or she were the employee's dependent.

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 or reduction of hours of employment, death of the employee, or the employee's is 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 the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator 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 or reduction of the employee's hours 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 8 months before the date on which his employment terminates, COBRA continuation coverage for his 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 8 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: The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment.

To benefit from this extension, a qualified beneficiary must notify the Plan Administrator or designated Plan Service Provider of the disability determination on or before 60 days from the COBRA start date, and before the end of the original 18-month period. If you do not notify the Plan Administrator or the designated Plan Service Provider within the required period of time, you may lose your right to the extension.

The affected individual must also notify the Plan Administrator or designated Plan Service Provider within 30 days of any final disability determination that the individual is no longer disabled. Coverage will end on the first of the month, following at least 30 days after the date of the Social Security final disability determination letter.

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.

Your Election Rights: When the Plan Administrator or designated Plan Service Provider is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage (because of one of the events described above) to inform the Plan Administrator or the designated Plan Service Provider that you want continuation coverage. If you do not choose continuation coverage in a timely manner, your group health insurance coverage will end.

Coverage Rights: If you choose continuation coverage, the Plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. Each covered person 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.

Maximum Period of Coverage: The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment (for reasons other than gross misconduct) or reduction in hours. In that case, the required continuation coverage period is 18 months. These 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period. In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

California State Residence: Under California law, you may be eligible for a State mandated extension of benefits after your federally mandated COBRA period expires. California State laws allow an extension of COBRA benefits to a total of 36 months from the date of your qualifying event to Qualified Beneficiaries who begin COBRA coverage on or after January 1, 2003. You will be notified of this extension at the conclusion of your original COBRA coverage.

Flexible Spending Account or Medical Reimbursement Account: If you are participating in the company's Flexible Spending Account or Medical Reimbursement Account at the time of your termination or reduction of hours, you may also have the right to continue participation under COBRA based on the following parameters:

1. You will be allowed to continue coverage for the remainder of the current plan year if you have a balance remaining in your account at the time of your termination or reduction in hours;
2. You will not be able to receive reimbursements in excess of your original election amount in the account; and
3. You make monthly payments in the same amount as your regular payroll deductions while you were an active employee.

Adding Dependents to COBRA Coverage: A child who is born to or adopted by the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator or designated Plan Service Provider of the birth or adoption.

Expiration of COBRA Coverage: The law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The company no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered - after the date he or she elects COBRA coverage - under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Limits to Pre-Existing Conditions: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follow:

If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Insurance Premiums: Under the law, you may have to pay all or part of the premium for your continuation coverage. You may also be required to pay a 2% administration fee above the cost of the premiums. If you are disabled, you may be required to pay 150% of the premium during the 11-month extension period.

Grace Period: There is a grace period of 30 days for payment of the regularly scheduled premium.

Conversion Coverage: At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries may be allowed to enroll in an individual conversion health plan provided a conversion health plan is available to active employees. Please read your health plan benefits booklet or Summary Plan Description regarding any option for conversion coverage after the expiration of COBRA coverage. If there is an option for conversion to an individual policy, follow the instructions provided to apply for the coverage, as it would be separate coverage, and would not simply be an extension of COBRA coverage.

IF YOU HAVE QUESTIONS

This notice does not fully describe continuation coverage or other rights under the Plan. More complete information regarding such rights is available from the Plan contact identified below and throughout the summary plan description. 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, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act (PPACA), 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

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

COBRA Contact Information:
If you have any questions about your rights to COBRA continuation coverage, you should contact:

UnitedHealthcare
P.O. Box 221709
Louisville, KY 40252

Customer Care Center
Toll Free: 866-747-0048
email: cobra_kyoperations@uhc.com
www.uhcservices.com

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA) NOTICE

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage.

The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having other health insurance or group health plan coverage at the time of your eligibility to participate, you may enroll yourself or your dependents at a future point, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days of such an event.

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your Plan Administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at 312-353-0900.

If you have any questions about this notice or the law, please contact your Plan Administrator listed below.

State of Ohio
Ohio Department of Administrative Services
Benefits Administration Services
Medical Plan Benefits Manager
30 East Broad St., 27th Floor
Columbus, OH 43215
800-409-1205 (option 2)

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

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 (option 2) or 800-409-1205 (option 2).

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 health care professional in our network who specializes in obstetrics or gynecology. The health care 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 health care professionals who specialize in obstetrics or gynecology, contact Medical Mutual at 800-822-1152 or UnitedHealthcare at 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, 2015, to June 30, 2016, with the State of Ohio and 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 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.

- The State of Ohio has determined that the prescription drug coverage offered by Catamaran 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 Oct. 15 through Dec. 7. 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 Catamaran 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.

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 1 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 October to join.

For more information about this notice or your current subscription prescription drug coverage…

Contact the person listed below for further information at 800-409-1205 (option 2).

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 (800-633-4227). TTY users should call 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 800-772-1213 (TTY 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).

July 1, 2015

State of Ohio
Ohio Department of Administrative Services
Benefits Administration Services
Prescription Drug Benefits Manager
30 East Broad St., 27th Floor
Columbus, OH 43215
800-409-1205 (option 2)

Glossary

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

Benefit Year/Plan Year: The 12-month period from July 1 through June 30 during which services are rendered and your deductible and coinsurance are accumulated.

Biometric Screening: A private screening with a health professional that provides a snapshot of your health. The screening includes cholesterol (total), HDL, LDL, blood glucose, blood pressure, height, weight and waist circumference.

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.

Covered Person: The employee, the employee's spouse and/or dependent children who are eligible and enrolled under your health care plan.

Covered Services: Those services and supplies provided for the purpose of preventing, diagnosing or treating a medical condition, behavioral disorder, psychological injury or substance abuse addiction for which the plan will provide benefits.

Deductible: The amount you pay for eligible expenses each plan year before the plan begins to pay anything. This does not apply to preventive services covered at 100 percent.

Eligible Expense: The maximum amount on which payment is based for covered health care services. You may be required to pay a percentage of Eligible Expenses in the form of Coinsurance.

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

Exempt Employee: An appointment to a position 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.

Flexible Spending Accounts (FSA): A type of savings account that provides the account holder with specific tax advantages. The account allows employees to contribute a portion of his or her regular earnings to pay for qualified expenses, such as for medical or dependent care. The two types of FSAs are health care spending accounts and dependent care spending accounts.

House Bill 1 (HB 1): Ohio House Bill 1, enacted by the 128th General Assembly, created a new category of eligibility for the state medical plan. Medical coverage, including prescription drug and behavioral health benefits, is available to overage dependents up to age 28 only. A special rate applies for these dependents. For eligibility requirements, refer to das.ohio.gov/EligibilityRequirements.

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. There is a separate out-of-pocket maximum for prescription drugs.

Patient Protection and Affordable Care Act (also known as the Affordable Care Act or PPACA or simply ACA): The health reform legislation passed by Congress and signed into law in March 2010 by the president of the United States.

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 Share or Contribution: The portion of the total premium the State of Ohio pays to provide its employees with coverage.

Summary of Benefits and Coverage (SBC): A requirement of the Patient Protection and Affordable Care Act, the SBC is a concise four-page document that details simple and consistent information about health plan benefits and coverage. It will help you understand the basics of your coverage and allow you to compare any different coverage options you may have. It summarizes the key features of the plan, such as covered benefits, cost-sharing provisions, and limitations and exceptions. All insurance companies and group health plans must use the same standard SBC form. The SBC also contains a link to the required Uniform Glossary, which provides definitions of many commonly used health coverage and medical terms. For full details, visit das.ohio.gov/benefits. The SBC is listed along the right navigation pane under the Publications and Notices section.

Third-Party Administrator (TPA): An organization or company that processes claims and other aspects of employee benefits plans on behalf of an employer. For example, Medical Mutual of Ohio and UnitedHealthcare are the third-party administrators of the Ohio Med PPO.

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

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.

Well-Being Assessment: A confidential questionnaire that assesses your physical, emotional and social health and how your lifestyle habits affect your overall well-being.

Well-Being Plan: A personalized summary of your overall well-being that offers personalized steps and recommendations.

Notes

SAVE THE DATES

2015

May
- Open Enrollment begins May 4
- Open Enrollment ends May 15

June
- *Let's Move It* Challenge ends June 8
- Benefit year ends June 30

July
- New benefit year begins July 1

October
- Flexible Spending Accounts Open Enrollment begins Oct. 19
- Flexible Spending Accounts Open Enrollment ends Oct. 30

November
- Great American Smokeout – Nov. 19

December
- Use your remaining Flexible Spending Accounts money by Dec. 31

2016

January
- New Flexible Spending Accounts plan year begins Jan. 1

February
- National Wear Red Day – Feb. 5

March
- 2015 Flexible Spending Accounts claims deadline – March 31

OhioDAS
Service · Support · Solutions
Department of Administrative Services

Ohio Department of Administrative Services
Human Resources Division
30 E. Broad St., 28th Floor
Columbus, Ohio 43215

2015 OPEN ENROLLMENT

MAY 4 TO 15

OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES + THE JOINT HEALTH CARE COMMITTEE

2015