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OhioDAS and the
Joint Health Care
Committee

SPRING EDITION



Pathways

Open Enrollment 2009

Important Information You Need to Know

- Benefits Changes
- Health Plan Coverage Differences
- Core Benefits
- Pharmacy/Dental/Vision Benefits
- Available online at das.ohio.gov/benefits

your path to wellness



Ohio The State of Perfect Balance

OhioDAS
Ohio Department of Administrative Services

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Ted Strickland,
Governor

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Administrative Services

Human Resources
Division

Benefits Administration
Services

das.ohio.gov/benefits

Overview

As part of Your Total Rewards package, State of Ohio employees are offered health care benefits at an affordable and competitive price. To help ensure that you receive the most value from your benefits, you are encouraged to review this guide to learn more about your health care options. Take a moment to assess your current benefits needs, compare health insurance plans and identify the best plan for you and your family.

What is Open Enrollment?

Open Enrollment is the period when you are given an opportunity to review your current benefit elections, review insurance plans and make benefit changes to meet your needs and the needs of your family.

How do I enroll or make changes to my current health care benefits?

Access the Ohio Administrative Knowledge System (OAKS) Self Service at eBenefits.ohio.gov.

You will need your OAKS Employee ID to enroll. If you have forgotten your Employee ID number you may contact the Ohio Department of Administrative Services Human Capital Management Customer Service Unit:

E-Mail: DASHRD.HCMOAKSSUPPORT@das.state.oh.us
Phone: 614.466.8857 or 1.800.409.1205

Click on the 2009 Open Enrollment link at das.ohio.gov/benefits to learn how-to:

- Reset your OAKS log-in password.
- Update your OAKS System Profile.
- Obtain a paper enrollment form.
- Identify the health care plan options available in your ZIP code.

You may access OAKS Self Service at eBenefits.ohio.gov to make changes:

May 4-8, and May 11-15: All day except 7 pm to 9 pm.
Saturday, May 9: All day except 4 pm to 6 pm.
Sunday, May 10: All day except 4 pm to midnight.
Saturday, May 16: All day except 4 pm to 6 pm.
Sunday, May 17: All day through OAKS Self-Service ending at midnight.

You may make changes on a paper form (optional):

You may visit your agency's human resources office to obtain a Medical Benefit Enrollment and Change Form (ADM 4717) or you may access the form online at das.ohio.gov/benefits by clicking on the 2009 Open Enrollment link.

Fill out the form and submit it to your agency's human resources office no later than Sunday, May 17.

Open Enrollment begins at 7am, Monday, May 4 and will continue through Sunday, May 17. Changes made during Open Enrollment will become effective July 1.

Benefits Changes Effective July 1, 2009

Current Benefit Year	New Benefit Year (July 1, 2009)
For Ohio Med, mail order for prescription drugs is mandatory.	For Ohio Med, mail order is voluntary.
Some preventive services and immunizations covered at 100%.	Preventive services covered at 100% (following USPSTF and CDC guidelines).
Insulin prescriptions require copay.	Insulin prescriptions covered at 100% if enrolled in the <i>Take Charge! Live Well!</i> program.
No coverage for tobacco cessation products.	Tobacco cessation products such as medications, gum, patches and lozenges are now covered (with a prescription).
Office copay \$15.	Office copay \$20.
No deductible for HMOs.	\$200 single/\$400 family deductible applies to all plans.
Out-of-pocket maximums are \$1,000 single and \$2,000 family.	Out-of-pocket maximums are \$1,500 single and \$3,000 family (\$3,000 single/\$6,000 family for Ohio Med non-network).
Payroll deductions for health care occur twice a month (24 total).	Payroll deductions for health care occur every pay period (26 total).

Eligibility

Health Care Coverage

Most state employees are eligible for health care coverage effective the first day of the month following their date of hire.

Dental and Vision Coverage

Exempt and union-represented employees are eligible to enroll in dental and vision coverage after completing one full year of continuous state service.

Dependent Coverage

The following are eligible to enroll as dependents:

- An employee's current legal spouse.
- An employee's and the legal spouse's unmarried children (including legally adopted children, children for whom either the employee or spouse has been appointed legal guardian and dependent stepchildren and foster children who normally reside with you until the end of the month in which they reach age 19).
- Unmarried children noted above who are age 19 or older, who are attending an accredited school and are primarily dependent on the employee or their current legal spouse for maintenance and support, are eligible until the end of the month in which they either reach age 23 or cease being a student - whichever occurs first.
- Children of divorced or separated parents who are not residing with the employee but whom the employee is required by law to support.
- Unmarried children of any age who are incapable of self-support due to mental retardation, severe mental illness or physical handicap, whose disability began before age 23 and who are primarily dependent upon the employee.

continued...

**2009-2010
Benefits
Open
Enrollment**

**May 4-17
2009**

**Want to
keep your
current
benefits
coverage?**

If you want to remain in the same health care plan and you have no changes regarding dependents for the 2009 – 2010 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.



Union-represented employees will receive the Union Benefits Trust Enrollment Guide at their homes the week of April 27. The guide includes enrollment/change forms for your dental, vision and legal plans. Look for a separate “supplemental life enrollment kit” from Prudential with supplemental life information, rates and an enrollment form during the same period.

- Adopted children have the same coverage as children born to you or your spouse whether or not the adoption has been finalized. Coverage begins upon placement/custody.
- Stepchildren who currently are living in the employee’s home more than 50 percent of the time.
- Under all health plans, coverage for your dependents ends no later than the last day of the month in which they turn 23, unless they have been granted an extension as described above.
- When two state employees are married and have legally separate dependents, the employee who has coverage as a spouse may be included as a covered dependent as well as children not residing with the employee, but for whom the spouse is required by law to provide health insurance.
- Dependents of divorced employees may be enrolled on both parents’ family plans pursuant to a court order or joint-custody agreement. However, health plans do not allow duplicate payments for services and may not coordinate benefits. Check your health plan for details.

Your Health Care Benefits: HMO vs. PPO

When you’re **selecting health insurance**, choosing the network of health care providers is often the most important decision 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 health care providers organized into a network to deliver health care services to members at discounted rates. Health care plans for the 2009 - 2010 plan year include:

HMO providers: Aetna, The Health Plan, Paramount and UnitedHealthcare

PPO provider: Ohio Med

Before you select an HMO or PPO it’s important to understand the difference between the two.

What is an 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.

What is a 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.

PPO members are not required to stay within the PPO network, but there is a strong financial incentive to do so. For example, the PPO reimburses 80 percent of costs for care received within the network, but only 60 percent of costs for non-network care. Unless you prefer a particular doctor, it’s best to stay within your PPO network. Because non-network providers do not accept the payment from the insurance company as payment in full, they are allowed to bill you the difference between what the insurance company paid and what remains. This is called balance billing and does not apply to your out-of-pocket maximum.

Another scenario that demonstrates **the fundamental difference between a PPO and an HMO** concerns network changes. If you enroll in the Ohio Med PPO and your physician leaves the network, you have the option to continue seeing that doctor at the out-of-network benefit level. If you enroll in one of the HMOs and your doctor leaves the network, you will need to find another physician who is in the HMO network to receive any benefit.

Which is better? There isn't one right answer. If you are fortunate enough to have a choice between HMO and PPO coverage, you should evaluate the coverage offered by each and determine which one best meets the needs of you and your family. For more information, please visit das.ohio.gov/benefits.

Key Terms

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, an 80 percent coinsurance rate means you pay 20 percent and the plan pays 80 percent.
- **Copay:** A specified dollar amount you pay to a health care provider or pharmacy for eligible expenses such as office visits and prescriptions. Copays do not count toward your annual deductible.
- **Deductible:** The amount you pay for eligible expenses each plan year before the plan begins to pay anything.
- **Employee Contribution:** The portion of the total premium that you pay through pre-tax payroll deductions for your insurance coverage.
- **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. Deductible and coinsurance apply to the out-of-pocket maximum. Check with your health plan to determine if health plan copays apply toward your out-of-pocket maximum. Prescription copays do not apply to the out-of-pocket maximum.
- **State Contribution:** The portion of the total premium the state pays to provide employees with insurance coverage.
- **Total Premium:** The combination of the employee contribution and the state contribution.

The State of Ohio will conduct a dependent eligibility verification beginning with the new plan year July 1. To learn more, visit das.ohio.gov/benefits.



The Joint Health Care Committee members from OCSEA are:

Carol Bowshier,
Labor co-chair

Mal Corey,
Board of Directors
Rehabilitation and
Correction

Timothy Huntsman,
Industrial
Commission

Louella Jeter,
Board of Directors
Public Safety

Jim LaRocca
Board of Directors
Lottery Commission

Donna Westrick,
Board of Directors
Industrial Commission

JHCC members from other public employee unions:

Marty Brown Bard,
CWA

Joel Barden,
FOP

Vickie Miller,
OEA

Barbara Montgomery,
1199 SEIU

Larry Phillips,
OSTA

The union perspective ...

What you should know about changes to your health care benefits and the open enrollment process

*By Jim LaRocca (Ohio Lottery Commission),
a Joint Health Care Committee union member*

State of Ohio unionized employees enjoy a benefit that many don't – a voice when it comes to their health care.

As one of your union representatives on the Joint Health Care Committee (JHCC), my role is to ensure my fellow union members have a say about their health care benefits.

The JHCC committee, which is comprised of representatives from both labor and management, works year-round toward keeping health care affordable and accessible while maintaining quality. This can be a difficult balance, but the committee works diligently to find that middle ground.

Recently OCSEA (Ohio Civil Service Employees Association), the union I represent, wrapped up health care negotiations with the state. Some significant accomplishments and gains were made including no increase in the percent of employee contribution toward insurance premiums, no copay for preventive services and insulin, and the elimination of mandatory mail for maintenance drugs. However, some tough decisions had to be made, including the addition of a spousal surcharge and an increase of the out-of-pocket maximum and office copays.

Change is never easy, but in a tough economic climate change often is necessary.

In addition to contract changes, the state intends to initiate an independent eligibility verification.

- Eligibility verification is a process to verify dependents that have been listed for coverage on an employee's health care plan. This could include having to provide proof of eligibility for anyone currently covered under your plan.

While this process may take time, a little effort by all will make a significant difference. Statistics prove that plans such as ours with a large number of employees sometimes cover 3 to 5 percent of ineligible membership. This estimated \$6 million cost-saving measure will ensure individuals ineligible under the plan – such as divorced spouses and non-family members – are not covered and inappropriately receiving benefits at our expense.

During this year's open enrollment period, the state will make eligibility rules very clear. It's possible that anyone fraudulently carrying someone on his or her health plan could face recovery of expenses and possible disciplinary action, and the union's ability to fight such actions will be a losing battle.

My advice to all bargaining members during open enrollment is to pay close attention to eligibility rules and make sure you are abiding by them. Document any correspondence you may have with your agency's human resources office regarding this issue. If you have concerns or need assistance beyond your human resources office, please do not hesitate to contact your union steward.

Your Health Plan Coverage Differences

The following chart highlights the major differences between the health plan options.

Health Plan Coverage Differences						
Plan Feature	Ohio Med PPO ¹		Aetna HMO ¹	Paramount HMO	The Health Plan HMO	UnitedHealthcare HMO ¹
	In-Network	Out-of-Network				
Out-of-Network Services Covered	Not Applicable	Yes	No ²	No ²	No ²	No ²
Allergy Testing & Treatment	<ul style="list-style-type: none"> \$20 copay per office visit. Plan pays 80% for injections after deductible. 	<ul style="list-style-type: none"> \$30 copay per office visit. Plan pays 60% for injections after deductible. 	<ul style="list-style-type: none"> \$20 copay for office visit. Plan pays 80% after deductible. 	<ul style="list-style-type: none"> \$20 testing copay. \$20 copay per treatment. 	<ul style="list-style-type: none"> \$20 copay for office visit. 	<ul style="list-style-type: none"> \$20 copay for office visit. Plan pays 80% after deductible.
Chiropractic Care	<ul style="list-style-type: none"> Plan pays 80% after deductible. Unlimited visits. 	<ul style="list-style-type: none"> Plan pays 60% after deductible. Unlimited visits. 	<ul style="list-style-type: none"> \$20 copay per visit. Plan pays 80% after deductible. 20-visit limit per benefit year for spinal manipulation. 	<ul style="list-style-type: none"> \$20 copay per visit. 40-visit limit per year or \$750 maximum benefits. 	<ul style="list-style-type: none"> \$20 copay per visit. 20-visit limit per year. 	<ul style="list-style-type: none"> \$20 copay per visit. Plan pays 80% after deductible. 20-visit limit per year.
Hearing Loss (Accidental, Injury or Illness)	<ul style="list-style-type: none"> 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. 		<ul style="list-style-type: none"> \$20 copay for exams and follow-up services. Plan pays 50% after deductible for hearing aids up to \$1,000 lifetime maximum. 	<ul style="list-style-type: none"> \$20 copay for exams and follow-up services. Plan pays 80% after deductible for hearing aids. No lifetime maximum. 	<ul style="list-style-type: none"> \$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. 	<ul style="list-style-type: none"> \$20 copay for exams and follow-up services. Plan pays 80% after deductible for hearing aids. No lifetime maximum.
Hearing Loss (Natural)	<ul style="list-style-type: none"> Plan pays 50% after deductible for hearing aids up to \$1,000 lifetime maximum. Exams and follow-up services included in coverage. 		<ul style="list-style-type: none"> \$20 copay for exams. Plan pays 50% after deductible for hearing aids up to \$1,000 lifetime maximum. 	<ul style="list-style-type: none"> \$20 copay for exams and follow-up services. Plan pays 50% after deductible for hearing aids up to \$1,000 lifetime maximum. 	<ul style="list-style-type: none"> \$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. 	<ul style="list-style-type: none"> \$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	<ul style="list-style-type: none"> Plan pays 80% after deductible. Unlimited visits. 	<ul style="list-style-type: none"> Plan pays 60% after deductible. Unlimited visits. 	<ul style="list-style-type: none"> \$20 copay per visit. Plan pays 80% after deductible for up to 30 visits per year. 	<ul style="list-style-type: none"> \$20 copay per visit. 30-visit limit per year physical and occupational therapy combined. 30-visit limit per year speech therapy. 	<ul style="list-style-type: none"> Inpatient: Plan pays 80% after deductible. Outpatient: \$20 copay per visit. 20-visit limit per occurrence. 	<ul style="list-style-type: none"> Plan pays 80% after deductible. 30-visit limit per year physical and occupational therapy combined.
Urgent Care	<ul style="list-style-type: none"> \$25 copay per visit. Plan pays 80% after deductible. 	<ul style="list-style-type: none"> \$30 copay per visit. Plan pays 60% after deductible. 	<ul style="list-style-type: none"> \$25 copay per visit. Plan pays 80% after deductible. 	<ul style="list-style-type: none"> \$25 copay per visit. Plan pays 80% after deductible. 	<ul style="list-style-type: none"> \$25 copay per visit. Plan pays 80% after deductible. 	<ul style="list-style-type: none"> \$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.

Cost Comparison of Health Care Plan Options: Full-time Employee BiWeekly Rates

Comparing the Cost of Your Health Plan Options

Plan Name		Annual Deductible	Your Copayments (Office Visits)	Coinsurance	Your Out-of-Pocket Maximum	Employee Contributions (You Pay)	State Contributions (State Pays)	Total Premium Cost
Ohio Med (PPO) ¹	Network	\$200 single \$400 family	\$20	You pay 20% plan pays 80%	\$1,500 single \$3,000 family	\$26.74 single \$73.14 family minus spouse	\$150.49 single \$413.44 family minus spouse	\$177.23 single \$486.58 family minus spouse
	Out-of-Network	\$400 single \$800 family	\$30	You pay 40% plan pays 60% ²	\$3,000 single \$6,000 family ³	\$78.91 family plus spouse ⁴	\$413.44 family plus spouse	\$492.35 family plus spouse
Aetna (HMO) ¹	Network	\$200 single \$400 family	\$20	You pay 20% plan pays 80%	\$1,500 single \$3,000 family	\$30.50 single \$83.48 family minus spouse \$89.25 family plus spouse ⁴	\$143.69 single \$394.74 family minus spouse \$394.74 family plus spouse	\$174.19 single \$478.22 family minus spouse \$483.99 family plus spouse
Paramount (HMO)	Network	\$200 single \$400 family	\$20	You pay 20% plan pays 80%	\$1,500 single \$3,000 family	\$26.81 single \$73.37 family minus spouse \$79.14 family plus spouse ⁴	\$131.94 single \$362.40 family minus spouse \$362.40 family plus spouse	\$158.75 single \$435.77 family minus spouse \$441.54 family plus spouse
The Health Plan (HMO)	Network	\$200 single \$400 family	\$20	You pay 20% plan pays 80%	\$1,500 single \$3,000 family	\$27.88 single \$76.27 family minus spouse \$82.04 family plus spouse ⁴	\$147.03 single \$403.96 family minus spouse \$403.96 family plus spouse	\$174.91 single \$480.23 family minus spouse \$486 family plus spouse
UnitedHealthcare (HMO) ¹	Network	\$200 single \$400 family	\$20	You pay 20% plan pays 80%	\$1,500 single \$3,000 family	\$29.70 single \$81.26 family minus spouse \$87.03 family plus spouse ⁴	\$144.37 single \$396.61 family minus spouse \$396.61 family plus spouse	\$174.07 single \$477.87 family minus spouse \$483.64 family plus spouse

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.

⁴ Employees with a spouse will be charged an additional \$12.50 per month. Rates for employees with a spouse are \$5.77 more per biweekly pay than those employees without a spouse.

Differences in plan rates are the result of each health plan's design, claims history and administrative fees.

Note: The rates listed above are presented in biweekly totals. These amounts represent the amount that will be deducted from each paycheck.

Core Benefits

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

In-Network Core Benefits for All Health Plans	
Benefit/Service	Coverage Levels
Ambulance Service	<ul style="list-style-type: none"> Covered at 80%.
Diabetic Supplies and Insulin	<ul style="list-style-type: none"> Covered at 100% upon participation in <i>Take Charge! Live Well!</i> chronic condition management program; covered at 80% with no participation in the chronic condition management program.
Dietitian Services	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Covered at 80%; plans require a \$75 copay, which is waived if you are admitted.
Preventive Exams & Screenings	<ul style="list-style-type: none"> Preventive care covered at 100%. Covered at 80% for diagnostic screenings. Age restrictions may apply. Non-immunization preventive care coverage is subject to the U.S. Preventive Services Task Force (USPSTF) guidelines.
Immunizations	<ul style="list-style-type: none"> Covered at 100%. Immunization coverage is subject to the Centers For Disease Control and Prevention (CDC) guidelines.
Diagnostic, X-Ray and Lab Services	<ul style="list-style-type: none"> Covered at 100% in conjunction with preventive services; covered at 80% if not in conjunction with preventive services.
Home Health Care	<ul style="list-style-type: none"> Covered at 80%; limit of 100 visits or 180 days for all plans.
Hospice Services	<ul style="list-style-type: none"> Covered at 100% with no copay, time or dollar limitations.
Infertility Testing	<ul style="list-style-type: none"> Covered at 80%; some plans may require a \$20 copay. Coverage includes testing only.
Inpatient and Outpatient Services	<ul style="list-style-type: none"> Covered at 80%. Includes medical/surgical care while hospitalized and services from a personal physician, anesthesiologist or pathologist while hospitalized.
Maternity - Delivery	<ul style="list-style-type: none"> Covered at 80%.
Maternity - Prenatal Care	<ul style="list-style-type: none"> Office visits covered at 100%; tests/procedures covered at 80%.
Mental Health and Substance Abuse (Services Provided by OptumHealth, also known as United Behavioral Health)	<ul style="list-style-type: none"> Covered at 100%. Outpatient care: \$20 copay per visit; then plan pays 100%. \$100 copayment per admission for medically necessary, pre-approved inpatient care, then plan pays 100% with no limit to the number of admissions. No dollar limit for annual and lifetime maximums. Includes alcohol or drug addiction, depression or anxiety, stress, family conflict, illness and loss of a loved one.
Prostheses	<ul style="list-style-type: none"> Covered at 80%; covers initial and replacement prosthetic devices, both internal and external devices.
Skilled Nursing Facility	<ul style="list-style-type: none"> Covered at 80%; 180-day limit, additional days covered at 60%.

Note – Ohio Med enrollees: Information above assumes usage at in-network providers. If services provided are out-of-network, employees will incur additional costs through higher deductibles, lower coinsurance and balance billing. Benefits indicated above apply after your deductible is met.

Your Pharmacy Benefits

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

Type Of Medication	Retail (30-day supply)	Mail-Order (90-day supply)
Generic ¹	\$10 copay	\$25 copay
Preferred Brand-Name ¹	\$25 copay	\$62.50 copay
Non-Preferred Brand-Name: Generic Unavailable ¹	\$50 copay	\$125 copay
Non-Preferred Brand-Name: Generic Available ²	You pay \$50 copay plus the price difference between brand-name and generic, or cost of the brand-name, whichever is less.	You pay \$125 copay plus the price difference between brand-name and generic or cost of the brand-name, whichever is less.
Prilosec OTC ³	\$5 copay	\$12.50 copay
<p>¹ Please note that 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.</p> <p>² Please note that the amount charged to the individual for Non-Preferred Multi-Source Brand medications may be greater than the Non Preferred Brand copay.</p> <p>³ Please note that the copay is waived for the first retail fill of Prilosec OTC. There is no waived copay for mail order.</p>		
<p>Oral and injectable contraceptives, contraceptive patches, Intra-Uterine Devices (IUDs) and diaphragms are covered through your pharmacy benefits.</p>		
<p>Pharmacy copays do not apply toward annual out-of-pocket maximum.</p>		

Are You Utilizing Generic Medications to Save Money?

Using the generic equivalent of brand-name medication can save you money. The following brand-name medications now have or soon will have a generic equivalent available:

- Lamictal (for seizures/bipolar disorder), released January 2009.
- Imitrex (tablets) (for migraine headaches), released February 2009.
- Topomax (for seizures, migraine headaches and prophylaxis), released March 2009.
- Adderall XR (ADHD – Attention Deficit Hyperactivity Disorder), released April 2009.
- Prevacid (for GERD, Gastrointestinal Ulcers), release scheduled for May 2009.

- Starlix (for Type 2 Diabetes), release scheduled for September 2009.
- Valtrex (anti-viral), release scheduled for December 2009.

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 health plans beginning July 1. A retail 90-day supply copay is being considered. This copay, if implemented, will be established once a Pharmacy Benefit Manager (PBM) vendor for July 1 has been finalized.

Dental Plan

If you are an exempt employee, regardless of where you live, you can choose to participate in either the DeltaPreferred or the DeltaPremier 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 DeltaPreferred or DeltaPremier network. When making your coverage selection, be sure to check with your dentist to determine whether he/she belongs to the DeltaPreferred or DeltaPremier network.

Exempt Employees Only: Your Dental, Vision and Supplemental Life Insurance Benefits

If you are an exempt employee, the state pays the full cost for you and your eligible dependents to participate in the dental and vision plans. An exempt employee is eligible to participate in these programs after one year of continuous state service.

	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." Go through the login process and click on "Print ID Card."

Vision Plan

If you are an eligible exempt employee, you have the option of enrolling in either the Vision Service Provider (VSP) plan or the EyeMed Vision Care Plan. The following chart compares the two plans:

Service	VSP Plan		EyeMed Plan	
	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:	Plan pays 100%.	Plan pays maximum benefit of:
		\$25 \$35 \$52 \$52 \$62 \$0		\$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) Medically Necessary	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. Plan pays maximum of \$125 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. 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 15 for contact information.

Supplemental Life Insurance

If you are an exempt employee, you are eligible for supplemental life insurance coverage. If 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

- If 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.

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.

Supplemental Life Insurance Example

Tom is 38-years-old and a non-smoker. He decides to buy an additional \$40,000 in coverage for himself and \$20,000 in coverage for his wife (who is 40-years-old and a smoker). The cost of Tom's supplemental coverage is \$0.82 per \$10,000 of coverage, for a monthly cost of \$3.28 ($4 \times 0.82 = \3.28). The monthly cost for Tom's wife is \$1.76 per \$10,000, or \$3.52 ($2 \times \$1.76 = \3.52).

What Else You Need to Know When Purchasing Supplemental Life Insurance

- If you already have supplemental life coverage, you may increase your coverage by two times your basic annual earnings or \$150,000, whichever is less, without providing proof of good health.
- You can purchase supplemental and dependent life insurance in increments of \$10,000 to a maximum of \$500,000 for yourself and \$40,000 for your spouse.
- Your supplemental life insurance is portable. This means that if you leave state service, you can keep your insurance. Please note: This does not apply to your spouse or dependent coverage.

Supplemental Life Insurance Rate Chart

Monthly Cost per \$10,000 of Coverage

Age as of July 1, 2009	Non-smoker	Smoker
29 & 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 & older	\$20.94	\$32.95



Take Charge! Live Well!

When you participate in any of the state's health plans, you and your enrolled spouse are automatically eligible to participate in the *Take Charge! Live Well!* health and wellness program. The State of Ohio is committed to investing in the health of employees and their families. The state's *Take Charge! Live Well!* program is a confidential and voluntary health management program. Your benefits include services to help you maintain your good health and improve any health risks you may have. Visit our Web site at ohio.gov/tclw.

What's in it for Me? Up to \$200!

Employees enrolled in *Take Charge! Live Well!* can earn up to \$100 in incentives. Your enrolled spouse can earn another \$100 for a total of \$200 for married employees.

Even if you have already participated in *Take Charge! Live Well!*, you are eligible to participate again between July 1 and June 30, 2010 and earn incentives up to \$100 for yourself and \$100 for your spouse. Incentives are available for health assessment participation, working with a health coach and participating in an online lifestyle change program or worksite health screening.

What's New?

As of July, 1, APS Healthcare will be the service provider for all employees and spouses enrolled in any State of Ohio health plan, regardless of the plan. Contact APS at 1.866.272.5507 or visit <http://stateofohio.apshealthcare.com>.

Take Charge! Live Well! Services

Health Assessments - \$50 incentive

A confidential questionnaire completed annually. Upon completion, you receive a report summarizing your overall health and any health risks.

Health Screenings - \$25 incentive

Understanding your health includes "knowing your numbers." Free health screenings are offered at some work locations throughout the state for employees and spouses enrolled in a state health plan.

Health Coaching - \$50 incentive

A health coach may call and offer to help you set your personal health goals and identify ways to make them a reality. The health coach can help you with tobacco cessation, weight management, nutrition improvement, exercise, stress management, back care, blood pressure and cholesterol management.

Online Lifestyle Change Programs - \$25 incentive

You may prefer to use online programs to improve your health. APS Healthcare offers a number of free online programs for tobacco cessation, weight management, nutrition improvement, stress management, back care, depression and insomnia.

Tobacco Cessation

For assistance with tobacco cessation, you may work with a Health Coach or use an online tobacco cessation program. ***New for July 1: Pharmacy coverage for tobacco cessation products such as Chantix and Zyban; and nicotine patches, gum, and lozenges.***

Chronic Condition Management

Coaching from a registered nurse is available to help you care for yourself and your chronic condition. You may receive a call from an APS nurse if you have asthma, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure or diabetes.

Diabetes Program

When you work with the APS nurse to help manage your diabetes, you are eligible to receive diabetes supplies and insulin with no copay. For more information call APS at 1.866.272.5507.

Free Nurse Advice Line

Advice and help are available 24 hours a day from the APS free Nurse Advice Line. Call 1.866.272.5507 and select option 3 for help with health questions and decisions.

Health and Other Benefits

Aetna HMO 1.800.520.4785
www.aetnastateohioemployee.com
Group Number 619316

Ohio Med PPO 1.800.822.1152
www.mmoh.com
Group Number 228000

Paramount HMO 1.800.462.3589
www.paramounthealthcare.com
Group Number 030291

The Health Plan HMO 1.800.624.6961
www.healthplan.org
Group Number 01809184

UnitedHealthcare HMO 1.877.442.6003
www.myuhc.com
Group Number 702097

**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
<http://stateofohio.apshealthcare.com>

Other Benefits-Exempt Employees

Delta Dental of Ohio 1.800.524.0149
www.deltadentaloh.com
Group Number 9273-0001 (Preferred)
Group Number 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
<http://www.standard.com/mybenefits/ohio/>

**Supplemental Life
Prudential Life Insurance** 1.800.778.3827
Group Number LG-93046

FREE 24-Hour Nurse Advice Line

1.866.272.5507, option 3

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

MetLife Dental
1.800.984.8649
Group Number
85100

Prudential Life
Insurance
1.800.778.3827
Group Number
LG-01049

Working
Solutions Program
1.800.358.8515

Hyatt Legal Services
1.800.821.6400

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)

Other Contacts

Ohio Department
of Administrative
Services Human Capital
Management Customer
Service Unit
1.800.409.1205
614.466.8857
das.ohio.gov/benefits

Union Benefits Trust
1.800.228.5088
614.508.2255
www.benefitstrust.org



OhioDAS
30 E. Broad Street
Columbus, Ohio 43215

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