OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES + THE JOINT HEALTH CARE COMMITTEE

SPRING 2012

Pathways to my Benefits

OPEN ENROLLMENT

MAY 7 TO 21, 2012

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Pathways to myBenefits

Your Path to Wellness 2012

Welcome to the Open Enrollment edition of *Pathways to myBenefits* magazine. Although there are few changes to the health plans this year, there is still some very important information to note about these changes. Readers should reference the charts throughout this publication because some information has changed for this new plan year.

In addition, as you review the coverage for you and your family, please consider whether your dependent coverage needs to be updated for the upcoming benefits year, which begins July 1, 2012.

New for the upcoming benefits year:

- A new vendor, Healthways, will manage the state's population health management program commonly known as *Take Charge! Live Well!* (See Page 11.)
- Improvements were made to allow diabetic supply program enrollees more options to receive free diabetic supplies. (See Page 11.)
- Prudential will be sending a supplemental life package to eligible exempt employees. For this Open Enrollment period only, Prudential is offering a supplemental life insurance enhancement without providing proof of good health. Prudential also is offering an ongoing enhancement in relation to plan maximums. (See Page 14.)

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das.ohio.gov/benefits

myBenefits Open Enrollment

This year's Open Enrollment period will be held from May 7 to 21. Following is some helpful information for you to review prior to Open Enrollment.

Employees and their dependents who currently are enrolled in medical coverage do not need to take any action to continue coverage into the next benefits year, which begins July 1. Your other coverage, such as dental, vision and supplemental life, also will remain the same unless you elect to make changes. To ensure any dependents still meet the eligibility requirements, visit: das.ohio.gov/eligibilityrequirements.

Any eligible employees who currently are not enrolled or who need to make changes to medical, dental, vision and supplemental life coverage can do so during Open Enrollment, which is being held from Monday, May 7 through Monday, May 21.

All choices made during Open Enrollment will become effective July 1. 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, go to: das.ohio.gov/qualifyingevents.

Starting on Page 16, you will find enrollment instructions, contact information, required legal notices related to your benefits and a glossary of common benefits terms.

ELIGIBILITY FOR BENEFITS

EMPLOYEES

- Medical – Most state employees are eligible to enroll in medical coverage (including prescription drug and behavioral health benefits) effective the first day of the month following their date of hire or during Open Enrollment.
- Dental and Vision – Exempt and union-represented employees are eligible to enroll in dental and vision coverage after completing one full year of continuous state service or thereafter during Open Enrollment.
- Basic Life – Exempt and union-represented employees are eligible for basic life coverage after completing one full year of continuous state service. Enrollment is automatic.
- Supplemental Life – Exempt and union-represented employees are eligible for coverage on their date of hire and have 90 days to enroll. Employees also may enroll or make changes during Open Enrollment.[1]

[1]Certain new enrollments or increases are subject to evidence of insurability. Coverage will begin the latter of either the first day of the month following your initial payroll deduction or after Prudential decides the evidence is satisfactory.

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 by June 4. 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 the following page for further guidance.

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 DAS 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[2]
Children ages 23 - 25	Coverage available for eligible dependents[1]	No coverage available	No coverage available	No coverage available
Children ages 26 - 27	Coverage available for eligible HB1 dependents[1]	No coverage available	No coverage available	No coverage available

[1]View detailed eligibility and documentation requirements at: das.ohio.gov/eligibilityrequirements.
[2]View eligibility requirements on Prudential enrollment form.

Note: When one of your enrolled dependents is or becomes ineligible for benefits coverage based on the state's definition of eligibility, it is your responsibility to contact your agency benefits specialist (or human resources office) immediately to remove them from your coverage. Your dependent may be eligible to continue their medical, dental and/or vision benefits through 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.

Medical Benefits

YOUR COVERAGE AT A GLANCE

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. Employees have access to both network and non-network providers. For deduction information, see charts on Page 7.

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

Medical Mutual and UnitedHealthcare each serve a specific region in Ohio based upon home ZIP codes. **The administrator you are assigned is based on the first three digits of your home ZIP code.** Please review the charts below that feature the ZIP code breakdown by plan administrator. Employees with home ZIP codes outside Ohio are enrolled in UnitedHealthcare.

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

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 17. You can visit your third-party administrator's website to download and print the information, call their customer service unit to request that it be mailed to you, or visit the DAS Open Enrollment Web page at: das.ohio.gov/OpenEnrollment2012.

How you can help!

CONTROL HEALTH CARE COSTS

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

OHIO MED PPO	
OUT-OF-POCKET COSTS	
Annual Deductible	Network: $200 single, $400 family; out of network: $400 single, $800 family.
Your Copayments (Office Visits)	Network: $20; out of network: $30.
Coinsurance	Network: You pay 20%, plan pays 80%; out of network: You pay 40%, plan pays 60%.[1]
Your Out-of-Pocket Maximum	Network: $1,500 single, $3,000 family; out of network: $3,000 single, $6,000 family.[2]
BENEFIT/SERVICE	**COVERAGE LEVELS**
Chiropractic Care	• 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; 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. • No lifetime maximum.
Home Health Care	• Covered at 80% 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 Care	• Office visits covered at 100% when billed separately from delivery; tests/procedures covered at 80% in network; 60% out of network.
Physical, Occupational and Speech Therapy	• Covered at 80% in network; 60% out of network. • Unlimited visits.
Preventive Exams & 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 benefit allowance and you pay any remaining balance.
[2] If your non-network charge is greater than the Ohio Med PPO allowance, your out-of-pocket costs will be more.

FULL-TIME EMPLOYEE MEDICAL DEDUCTIONS

	FULL-TIME / BIWEEKLY-PAID EMPLOYEE DEDUCTIONS[2]			FULL-TIME / MONTHLY-PAID EMPLOYEE DEDUCTIONS[2]		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$33.28	$187.53	$220.81	$72.11	$406.32	$478.43
Family Minus Spouse	$91.00	$514.60	$605.60	$197.17	$1,114.97	$1,312.14
Family Plus Spouse[1]	$96.77	$514.60	$611.37	$209.67	$1,114.97	$1,324.64

[1] Family Plus Spouse rates above include a charge of $12.50 per month to cover a spouse.
[2] These rates represent the total amount that will be deducted from your paycheck, including the communication surcharge.

PART-TIME EMPLOYEE MEDICAL DEDUCTIONS

	PART-TIME BIWEEKLY DEDUCTIONS[2] 75% TIER			PART-TIME BIWEEKLY DEDUCTIONS[2] 50% TIER		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$55.32	$165.49	$220.81	$110.40	$110.41	$220.81
Family Minus Spouse	$151.52	$454.08	$605.60	$302.80	$302.80	$605.60
Family Plus Spouse[1]	$157.29	$454.08	$611.37	$308.57	$302.80	$611.37

	PART-TIME BIWEEKLY DEDUCTIONS[2] 0% TIER		
	Employee Share	State Share	Total
Single	$220.81	$0.00	$220.81
Family Minus Spouse	$605.60	$0.00	$605.60
Family Plus Spouse[1]	$611.37	$0.00	$611.37

[1] Family Plus Spouse rates above include a charge of $12.50 per month to cover a spouse.
[2] These rates represent the total amount that will be deducted from your paycheck, including the communication surcharge.

ADDITIONAL RATES FOR EACH HB1 DEPENDENT (FOR ALL ENROLLED EMPLOYEES)	
Biweekly Deduction Amount:	$95.34
Monthly Deduction Amount:	$206.57

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 health plan – Ohio Med PPO – 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 +

*HPV is recommended for males and females.

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

Prescription Drug

LOWER YOUR COST

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

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

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

90-DAY AT RETAIL PROGRAM

If you prefer to use your local retail pharmacy, you can receive a 90-day supply of medication at your pharmacy.

TYPE OF MEDICATION	30-DAY SUPPLY AT RETAIL COPAYMENT	90-DAY SUPPLY AT RETAIL COPAYMENT	90-DAY SUPPLY AT MAIL SERVICE COPAYMENT
Generic	$10	$30	$25
Preferred Brand-Name	$25	$75	$62.50
Non-Preferred Brand-Name, Generic Unavailable	$50	$150	$125
Non-Preferred Brand-Name, Generic Available	$50 plus the difference between the cost of the brand-name and generic drug	$150 plus the difference between the cost of the brand-name and generic drug	$125 plus the difference between the cost of the brand-name and generic drug

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

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

CATALYST RX "PRICE & SAVE" TOOL AVAILABLE

Catalyst Rx provides an online pricing tool that allows you to shop for the lowest priced pharmacies and medications.

To access Price & Save, visit catalystrx.com and enter your member ID as shown on your Catalyst Rx prescription drug card, your date of birth and the group number "STOH" in the "Member Log-in" box located in the right navigation pane; then, click **Login**. On the Member home page, click **Price & Save Drug Pricing Center** in the column of topics on the left side of the screen. Enter your prescription information and start saving!

SPECIALTY DRUG MANAGEMENT PROGRAM

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

NOT ALL DRUGS ARE COVERED

Some drugs require the use of alternative medications before being approved. This is known as "step therapy." Examples include medications used for heartburn, 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 by mail. A description of the program and a list of medications are on the Benefits Administration website at: das.ohio.gov/prescriptiondrug under "Important Prescription Drug Updates."

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

Behavioral Health

HELP ALWAYS AVAILABLE

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

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

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

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

OUT-OF-NETWORK BENEFITS

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

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

Out-of-network inpatient services are paid at 60 percent of the UBH-allowed amount instead of 80 percent and you may be balance billed for the difference between the facility charge and what UBH allows.

Wellness Program

NEW *TAKE CHARGE! LIVE WELL!* VENDOR BEGINNING JULY 1

Beginning July 1, Healthways will be the vendor for the *Take Charge! Live Well!* program.

For more than 30 years, Healthways has inspired more than 38 million people worldwide to achieve their personal best. By using proven health support techniques, quality medical information and caring health professionals, the Healthways team meets you where you are and takes you where you want to go, creating health and well-being for a better you.

With Healthways, you will have access to a robust website where you will be able to:

- Track incentive activity completion and delivery of incentives
- Track day-to-day exercise, nutrition and goals
- Register for challenges
- Access recipes and menus
- Chat live with a health coach

In the new benefits year, participants in the *Take Charge! Live Well!* program will have more choices of activities to earn incentives. In addition, instead of receiving your incentive in your paycheck, you will receive a Visa gift card in the amount of your incentive mailed directly to your home from Healthways. You will receive additional materials from Healthways in the coming months with more details about the program. In the interim, you can access answers to frequently asked questions at www.ohio.gov/tclw.

DIABETIC SUPPLY PROGRAM BEING ENHANCED

Employees and their dependents who participate in the *Take Charge! Live Well!* program for diabetes will experience some program enhancements beginning July 1:

- Liberty will no longer be the preferred supplier for diabetic supplies; the mail-order requirement is being discontinued.
- Free diabetic supplies can be obtained at any retail pharmacy in either a 30-day or 90-day supply.
- Diabetic supplies can be obtained through the Catalyst Rx Immediate Pharmaceutical Services (IPS) mail-order pharmacy for a 90-day supply.

To prepare for this change, participants in the *Take Charge! Live Well!* diabetic supply program should take the following steps:

1. Obtain new prescriptions for your diabetic supplies from your health care provider prior to July 1 unless your current supplies will last beyond that date.
2. Check with Catalyst Rx IPS mail-order pharmacy at 1.866.854.8850 or your retail pharmacy to make sure they can provide the supplies you currently are using.
3. Do not order supplies from Liberty after June 25. (Liberty will no longer be a provider under the program effective July 1.)

Employees enrolled in the diabetic supply program will receive additional information about program eligibility from Healthways, the state's new wellness vendor, in the coming weeks.

FOR EXEMPT EMPLOYEES

Dental and Vision

CHOOSE FROM MULTIPLE PLANS

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

EXEMPT DENTAL PLAN

If you are an exempt employee, regardless of where you live, you can choose to participate in either the Delta Dental PPO or the Delta Dental Premier plan offered through Delta Dental of Ohio. When you participate in either of the dental plans, you can go to the dentist of your choice and receive benefits. However, you will generally pay less when you go to a dentist who belongs to the **Delta Dental PPO** or **Delta Dental Premier** network. When making your coverage selection, be sure to check with your dentist to determine whether he/she belongs to the network. See Page 13 to view a plan comparison chart or Page 17 for plan contact information.

Print Your Delta Dental Card Online

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

EXEMPT VISION PLAN

Eligible exempt employees have the option of enrolling in the Vision Service Plan (VSP) or the EyeMed Vision Care plan. See Page 13 to view a plan comparison chart or Page 17 for plan contact information.

Did you know?

A primary difference between vision plans is the provider network. Be sure to check with your vision provider to determine whether your provider belongs to the **VSP Signature** network or EyeMed Vision Care's **Select** network. Check with each plan for a complete provider list. Turn to Page 17 for plan contact information.

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. A separate "Supplemental Life Enrollment Kit" from Prudential will arrive during the same period and will include information about supplemental life, rates and an enrollment form.

EXEMPT DENTAL PLAN

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

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 available in both plans.

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

EXEMPT VISION PLAN

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

FOR EXEMPT EMPLOYEES

Life Insurance

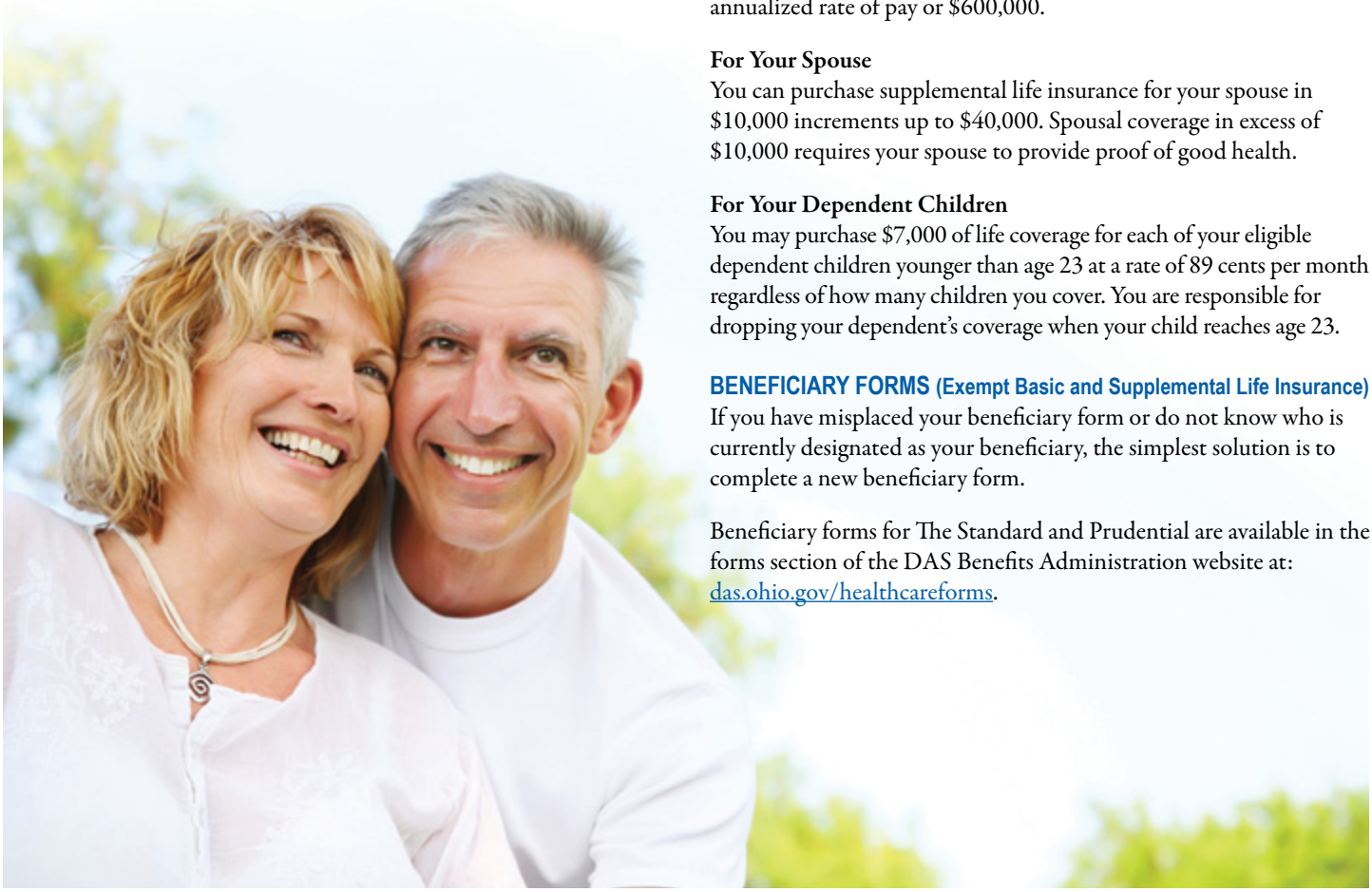
ENJOY PEACE OF MIND

The State of Ohio pays the full cost for you to participate in the basic life plan. Exempt employees are automatically enrolled in the basic life plan after one year of continuous state service. For supplemental life insurance, exempt employees may enroll in the program during Open Enrollment. New employees may enroll in the program within 90 days of their hire date.

EXEMPT BASIC LIFE INSURANCE

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

The IRS requires that employees be taxed on the value of employer-paid group life insurance coverage exceeding $50,000. This is known as "imputed income." If your 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 Page 15 for the imputed income rate chart.



EXEMPT SUPPLEMENTAL LIFE INSURANCE

Some exempt employees are eligible for supplemental life insurance coverage through Prudential. When you enroll for the 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 15 for the rate chart and Page 17 for plan contact information.

For Yourself

Without proof of good health: During this Open Enrollment period only, current participants or exempt employees purchasing supplemental life coverage for the first time have the opportunity to increase your current coverage level or elect up to either the lesser of three times your annualized rate of pay or $230,000 without providing proof of good health. This opportunity is available only during this Open Enrollment.

With proof of good health: Another option is a new plan enhancement that offers exempt employees the ability to elect up to either the lesser of eight times your annualized rate of pay or $600,000 with acceptable proof of good health.

Elections must be rounded up to the next $10,000 increment and coverage may not exceed either the lesser of eight times your annualized rate of pay or $600,000.

For Your Spouse

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

For Your Dependent Children

You may purchase $7,000 of life coverage for each of your eligible dependent children younger than age 23 at a rate of 89 cents per month regardless of how many children you cover. You are responsible for dropping your dependent's coverage when your child reaches age 23.

BENEFICIARY FORMS (Exempt Basic and Supplemental Life Insurance)

If you have misplaced your beneficiary form or do not know who is currently designated as your beneficiary, the simplest solution is to complete a new beneficiary form.

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

IRS BASIC LIFE IMPUTED INCOME CHART (Monthly Cost Per $1,000 of Coverage in Excess of $50,000)	
AGE	COSTS
Younger than 25	$0.05
25 through 29	$0.06
30 through 34	$0.08
35 through 39	$0.09
40 through 44	$0.10
45 through 49	$0.15
50 through 54	$0.23
55 through 59	$0.43
60 through 64	$0.66
65 through 69	$1.27
70 and older	$2.06

EXEMPT SUPPLEMENTAL LIFE INSURANCE RATE CHART (Monthly Cost per $10,000 of Coverage)		
AGE AS OF JULY 1, 2012	NON-SMOKER	SMOKER
Younger than 30	$0.53	$0.70
30 through 34	$0.65	$0.70
35 through 39	$0.74	$1.03
40 through 44	$1.17	$1.58
45 through 49	$1.81	$2.63
50 through 54	$2.82	$4.05
55 through 59	$4.52	$6.02
60 through 64	$6.85	$9.23
65 through 69	$11.12	$16.57
70 and Older	$18.85	$29.66

Benefits Enrollment Instructions

If you are not currently enrolled or you want to add or remove a dependent from your current coverage, 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 HR Customer Service at 1.800.409.1205.

2. Enroll in coverage or make changes to your dependents' medical, dental and vision online at: myOhio.gov or by using a paper enrollment and change form available from your agency benefits representative or online at the DAS Benefits Administration website at: das.ohio.gov/healthcareforms.

   A. **ONLINE** – Go to: myOhio.gov.

   - Enter your Employee ID number and password.

     If you have forgotten your Employee ID number or your password, contact HR Customer Service by calling toll-free, 1.800.409.1205, 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.
   - Click on **Enroll in Benefits**.
   - For detailed instructions on how to enroll or make changes online, go to: das.ohio.gov/enrollmentinstructions.
   - Online Open Enrollment is available May 7 to 21, 2012, 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/or dental/vision coverage for exempt employees, obtain a paper **State of Ohio Benefit Enrollment/Change Form (ADM 4717)** on the DAS Benefits Administration website at: das.ohio.gov/healthcareforms or from your agency's human resources office.

3. Submit your enrollment or changes:

   A. **ONLINE** – Make and submit your selections through myOhio.gov by Monday, May 21. Make sure your online changes are correctly submitted. At the end of the process you will receive a confirmation message.

   B. **PAPER** – Give your completed and signed **State of Ohio Benefit Enrollment/Change Form (ADM 4717)** to your agency's human resources office by 4 p.m. Monday, May 21.

Following Open Enrollment you 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 adding new dependents during this Open Enrollment, you are required to provide the required eligibility documentation for your dependents. A listing of the required documentation can be found at: das.ohio.gov/eligibilityrequirements.

Coverage will not be provided for dependents until the eligibility documents are received and approved. The final deadline to submit all required documentation is July 31.

Health and Other Benefits Contacts

ALL EMPLOYEES

Medical
Medical Mutual of Ohio
1.800.822.1152
medmutualstateohioemployee.com
Group Number: 228000

UnitedHealthcare
1.877.440.5977
welcometouhc.com/ohio
Group Number: 702097

Prescription Drug
Catalyst Rx
1.866.854.8850
catalystrx.com
Rx Group #: STOH

Behavioral Health & Substance Abuse
United Behavioral Health
1.800.852.1091
liveandworkwell.com
Website Access Code: 00832

Employee Assistance Program
1.800.221.6327
odh.ohio.gov/eap/eap.aspx

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

24-Hour Nurse Advice Line
1.866.272.5507, Option 3

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

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

EXEMPT EMPLOYEES ONLY

Dental
Delta Dental of Ohio
1.800.524.0149
deltadentaloh.com
PPO Plan
Group Number: 9273-0001
Premier Plan
Group Number: 9273-1001

Vision
Vision Service Plan (VSP)
1.800.877.7195
vsp.com
Group Number: 12022518

EyeMed Vision Plan
1.866.723.0514
eyemedvisioncare.com
Group Number: 9676008

Life Insurance
Basic Life Insurance
The Standard
1.866.415.9518
standard.com/mybenefits/ohio
Group Number: 645571

Supplemental Life Insurance
Prudential Life Insurance
1.800.778.3827
prudential.com/mybenefits
Group Number: 93046

UNION-REPRESENTED EMPLOYEES ONLY

Dental
Delta Dental of Ohio
1.877.334.5008
Group Number: 1009

Vision
Vision Service Plan
1.800.877.7195
Group Number: 12022914

EyeMed Vision Care
1.866.723.0514
Group Number: 9674813

Life Insurance
Prudential Life Insurance
1.800.778.3827
Group Number: LG-01049

Employee Assistance Program
Working Solutions Program
1.800.358.8515
Group Number: 4718

Legal Services
Hyatt Legal Services
1.800.821.6400
Group Number: 4900010

Union Benefits
Union Benefits Trust
614.508.2255
1.800.228.5088

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

Ohio Department of Administrative Services
HR Customer Service

614.466.8857 / 1.800.409.1205

HRCustomerService@das.state.oh.us
das.ohio.gov/benefits

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 if call is regarding claims.

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

Notice of Privacy Practices

Effective June 1, 2011

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 partners (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 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. We 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. 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 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 and may not include dates before April 14, 2003. 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 listed below. The Plan will post a copy of the current notice at das.ohio.gov.

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. 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 Secretary of
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:

Ohio Department of Administrative Services
HIPAA Privacy Contact
30 East Broad St., 27th Floor
Columbus, OH 43215
Phone Number: 614.466.6205
Email: gregory.pawlack@das.state.oh.us

Continuation Coverage Rights Under COBRA

Introduction

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

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

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

Disability extension of 18-month period of continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information:

COBRA Administrator
Ohio Department of Administrative Services
Benefits Administration Services
30 E. Broad Street, 28th Floor, Columbus, OH 43215
1.800.409.1205, Option 5

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

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

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

1. all stages of reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

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

Newborns' and Mothers' Health Protection Act

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

Patient Protection

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

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

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

Creditable Coverage Disclosure:

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage, effective July 1, 2012, to June 30, 2013, 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 Catalyst Rx is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from 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 Catalyst Rx is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

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

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

For more information about this notice or your current subscription prescription drug coverage…
Contact the person listed below for further information at 1.800.409.1205.

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

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

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

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

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

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

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

July 1, 2012

State of Ohio
Ohio Department of Administrative Services
Benefits Administration Services
Prescription Drug Benefits Manager
30 East Broad, 27th Floor
Columbus, OH 43215
1.800.409.1205

GLOSSARY

When reviewing information about your health care coverage options, it's 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.

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

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

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

Employee Share: The portion of the total contribution that you pay through pre-tax payroll deductions for your medical coverage.

House Bill 1 (HB 1): Ohio House Bill 1 of 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 children up to age 28 only. A special rate applies for these children. Please refer to: das.ohio.gov/eligibilityrequirements for eligibility requirements.

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

Preferred Provider Organization (PPO): When you enroll in a PPO (medical or dental), you may visit any doctor and receive benefits. However, the benefit is less when you use providers that are not a part of the PPO network.

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

Third-Party Administrator (TPA): An organization or company that processes claims and other aspects of employee benefits plans on behalf of an employer.

OhioDAS | Department of Administrative Services

Ohio Department of Administrative Services
Human Resources Division
Benefits Administration Services

HR Customer Service
30 E. Broad St., 28th Floor
Columbus, Ohio 43215

Save the Dates

2012

May
- Open Enrollment begins May 7.
- Healthy Ohio Fitness Walk – May 16
- Open Enrollment ends May 21.

June
- Statewide Walking Challenge ends June 10.
- Wellness program participants must complete four coaching calls by June 30 to receive incentive.

July
- New benefits year and wellness program begin July 1.

October
- Flexible Spending Account Open Enrollment period

November
- Great American Smokeout – Nov. 15

December
- Use your remaining Flexible Spending Account money.

2013

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

February
- National Wear Red Day – Feb. 1

March
- 2012 Flexible Spending Account claims deadline – March 31.