

State of Ohio Employee Health Plans
30 East Broad Street, 27th Floor, Columbus, Ohio 43215
NOTICE OF PRIVACY PRACTICES

Effective July 1, 2019

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

PLEASE REVIEW IT CAREFULLY.

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

Position on Privacy

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

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

How the Plan May Use or Disclose Your Protected Health Information

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

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

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

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

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

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

In limited instances, the law allows the Plan to use and

disclose your PHI without your authorization in the following situations:

- A. As Required by Law. The Plan may disclose your PHI when required by federal, state or local law.
- B. Family and Individuals Involved in Your Care. The Plan may disclose 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 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 use and 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 for oversight activities authorized by law, such as: overall health care system monitoring, monitoring the conduct of government programs, and monitoring to ensure compliance with civil rights laws.
- G. Lawsuits/Legal Disputes. The Plan may use and 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 disclose 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 disclose 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 disclose 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 disclose 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 disclose 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 disclose 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 disclose 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 use and disclose PHI so they can provide services. The Plan will require that any business associates who receive PHI safeguard the privacy of that information.
- O. **Disclosure to You.** The Plan may disclose your medical information to you.

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

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

4. Changes to Existing Laws

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

Your Legal Rights

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

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. (For example, you could ask that the Plan not disclose or use information about a certain medical treatment you received.)

The Plan is not required to agree to your request. To request restrictions on the use or disclosure of your PHI, you must make your request in writing to the Plan's HIPAA Privacy Contact listed below. In your request, you must explain: (1) what PHI you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and, (3) to whom you want the limits to apply (for example, your spouse).

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

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

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

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures the Plan has made of medical information about you. This accounting will not include many routine disclosures including, but not limited to, those made to you or pursuant to your authorization, those made for treatment, payment and operations purposes as discussed above, those made for national security and intelligence purposes, and those made to law enforcement in compliance with law.

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

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

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

This Notice is Subject to Change

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

Whom to Contact

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

US Department of Health and Human Services

200 Independence Avenue, S.W.
Washington, D.C. 20201
1-877-696-6775

www.hhs.gov/ocr/privacy/hipaa/complaints

The Plan's HIPAA Privacy Contact

Gregory Pawlack
DAS – HIPAA Privacy Contact
30 East Broad St., 27th Floor
Columbus, Ohio 43215
614-466-6205

gregory.pawlack@das.ohio.gov

You will not be penalized or retaliated against for filing a complaint.

Special Enrollment Rights Pursuant to HIPAA

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

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

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having

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

If you have questions about this notice, please contact your Plan Administrator listed below:

State of Ohio

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

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your human resources representative.

The Women's Health and Cancer Rights Act of 1998

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 was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and,
4. Treatment of physical complications of all stages of mastectomy, including lymphedema.

For individuals receiving mastectomy-related benefits, coverage will be provided 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 or would like more information about the State of Ohio's WHCRA benefits, contact HR Customer Service at 614-466-8857 (option 2) or 800-409-1205 (option 2).

The Newborns' and Mothers' Health Protection Act

Under the provisions of The Newborns' and Mothers' Health Protection 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 Disclosure

The Ohio Med PPO and the Ohio Med HDHP generally allow 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 below for Anthem, and Medical Mutual of Ohio.

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

You do not need prior authorization from Anthem, Medical Mutual of Ohio, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact: Anthem at (1-844-891-8359); or, Medical Mutual of Ohio at (1-800-822-1152).

Creditable Coverage Disclosure for the Ohio Med PPO Plan

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. For those enrolled in the Ohio Med PPO Plan, this notice has information about your current prescription drug coverage 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 under the Ohio Med PPO Plan 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 October 15 to December 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 under the Ohio Med PPO Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

For further information, contact:

State of Ohio

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

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

For more information about your options under Medicare prescription drug coverage:

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

For more information about Medicare prescription drug coverage:

- Visit: medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (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).

Creditable Coverage Disclosure for the Ohio Med HDHP Plan

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. For those enrolled in the Ohio Med HDHP Plan, this notice has information about your current prescription drug coverage 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 the Ohio Med HDHP Plan 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 October 15th to December 7th. 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 under the Ohio Med HDHP Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

For further information, contact:

State of Ohio

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

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

For more information about your options under Medicare prescription drug coverage:

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

For more information about Medicare prescription drug coverage:

- Visit: medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (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).

Nondiscrimination and Accessibility Statement

Discrimination is Against the Law

The State of Ohio complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The State of Ohio does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If you need aids or other services to enable you to communicate effectively with the benefits representatives, please contact your agency's EEO Officer or your agency's human resources representative. You may also contact HR Customer Service at 614-466-8857 (option 2). These aids/services may include: qualified sign language interpreters; written information in other formats (e.g. large print, audio, accessible electronic formats); or, non-English interpreters. Any necessary aids or services will be provided at no cost to you.

If you believe that you've been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with your agency's EEO Officer, or you may file a complaint with the DAS Equal Opportunity Division at: (Website: www.das.ohio.gov/eod/aaeeo) (Phone: 614-466-8380).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Notice Regarding the Wellness Program

Take Charge! Live Well! is a voluntary wellness program available to all employees enrolled in the State of Ohio medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for total cholesterol, high density lipoprotein (HDL), low density lipoprotein (LDL), triglycerides, and blood glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to \$50 for completion of the HRA and \$100 for completion of a biometric screening. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives of up to \$200 may be available for employees who participate in certain health-related activities such as health coaching and online participation in health and wellness lessons and/or challenges. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation. You may request a reasonable accommodation by contacting Beth Kim at 614-728-5478.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching and QuitNet. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the State of Ohio may use aggregate information it collects to design a program based on identified health risks in the workplace, *Take Charge! Live Well!* will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of

providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the health coaching staff at Sharecare in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Beth Kim at 614-728-5478.

Notice of Initial COBRA Rights Continuation Coverage Rights Under COBRA

You are receiving this notice because you are covered under a group health plan (the "Plan") sponsored by your employer. It is intended to inform you, in a summary fashion, of your potential future options and obligations under the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Under COBRA, your employer is required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage, called continuation coverage, at group rates when coverage under the Plan would otherwise end due to certain "Qualifying events." It is important that all covered individuals read this notice carefully and be familiar with its contents. This notice does not fully describe continuation coverage or other rights under the Plan. More complete information is available from your employer and in the Plan's Summary of Benefits and Coverage, Summary Plan Description and Plan Document.

Your employer is not required to offer COBRA (and this notice does not apply to you) if all employers maintaining the Plan normally employed fewer than 20 full-time employees on a typical business day during the preceding calendar year. If you are not eligible for COBRA, you may be eligible for state continuation coverage. Contact the Plan for more information.

You may have other options available to you when you lose group health coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

Qualifying Events

If you are the covered employee, you may have the right to elect COBRA if you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours

of employment. **If you are the covered spouse of an employee**, you may have the right to elect continuation coverage for yourself if you lose group health coverage because of any of the following reasons: the death of your spouse; termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; divorce from your spouse; or your spouse becomes entitled to Medicare. If you are the covered dependent child of an employee, you may have the right to elect COBRA for yourself if you lose group health coverage because of any of the following reasons: the death of the employee; termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment; parents' divorce; the employee becomes entitled to Medicare; or you cease to be a dependent child under the terms of the health plan.

If the Plan provides retiree health coverage, filing a proceeding for reorganization under the Bankruptcy Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

If you are a reservist called to active duty and your employer does not voluntarily maintain coverage for the continuation coverage period, the employee, spouse and covered dependents may be eligible to continue coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Contact your employer for more information.

Under the law, the employee, spouse, or other family member has the responsibility to notify the employer of a divorce, legal separation, or a child losing dependent status under the group health plan. This notification must be made within 60 days from whichever date is later: the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event. Your employer has the responsibility to notify iTEDIUM, Inc. of the employee's death, termination, reduction in hours of employment or Medicare entitlement. **If this notification is not completed according to the above procedures within the required notification period, then rights to continuation coverage will be forfeited.**

Once iTEDIUM, Inc. learns a qualifying event has occurred, it will then notify all qualified beneficiaries of their right to elect continuation coverage. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect continuation coverage. The 60-day election period is measured from the later of the date health plan coverage is lost due to the event or from the date of COBRA notification, unless the Plan provides an extension of the election period beyond that required by law. **If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end.**

Length of Continuation Coverage

You have the right to continuation coverage for up to 18 months from the date of the qualifying event if the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours.

The 18 months of continuation coverage can be extended

for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if: the qualified beneficiary is deemed disabled (as determined by Title II or XVI of the Social Security Act), at any time during the first 60 days of COBRA continuation coverage; and the qualified beneficiary notifies iTEDIUM, Inc. within 60 days after the determination of disability is made by the Social Security Administration, and within the initial 18-month period of coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to iTEDIUM, Inc. within 60 days after the date of determination and before the original 18 months expire. It is also the qualified beneficiary's responsibility to notify iTEDIUM, Inc. within 30 days if a final determination has been made that they are no longer disabled.

If you are the covered spouse or dependent child(ren) of an employee, an extension of the 18-month continuation period can occur if, during the 18 months of continuation coverage, a second event takes place (divorce, death, Medicare entitlement, or a dependent child ceasing to be a dependent). If a second event occurs, then the original 18 months of continuation coverage can be extended to 36 months from the date of the original qualifying event date for the qualified beneficiary spouse and/or dependent children. If a second event occurs, it is the qualified beneficiary's responsibility to notify iTEDIUM, Inc. in writing within 60 days of the second event and within the original 18-month continuation period. In no event, however, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage.

If you are the covered spouse or dependent child(ren) of an employee, you have the right to continuation coverage for up to 36 months from the date of the qualifying event if the original event causing the loss of coverage was the death of the employee, divorce, Medicare entitlement, or a dependent child ceasing to be a dependent child under the Plan.

Qualified beneficiaries do not have to show they are insurable to elect continuation coverage; however, they must have been actually covered by the Plan for at least one day prior to the qualifying event to be eligible for COBRA. Although a qualified beneficiary participating in COBRA has the same rights as an active participant to add dependents to the Plan, those additional dependents may not be qualified beneficiaries. An exception to this rule is if, while on continuation coverage, a baby is born to or adopted by an employee/former employee. Procedures and deadlines for adding these individuals can be found in your summary plan description and must be followed. Your employer reserves the right to verify COBRA eligibility status and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

Cost of Continuation Coverage

A qualified beneficiary will have to pay the entire applicable premium plus an administration charge for continuation coverage as allowed by law, currently 2% of the total premium. These premiums will be adjusted in the future if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, your employer can charge up to 150% of the applicable premium during the extended coverage period. Premiums are due every month for continuation coverage. In addition there will be a maximum grace period of 30 days for the regularly scheduled monthly premiums.

Termination of Continuation Coverage

Continuation of coverage will end prior to the maximum period if:

- Your employer ceases to provide any group health plan to any of its employees;
- Any required premium for continuation coverage is not paid in a timely manner;
- A qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996.
- A qualified beneficiary becomes entitled to Medicare after the qualifying event except when the qualifying event is loss of retiree coverage due to the employer's bankruptcy;
- A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
- A qualified beneficiary notifies iTEDIUM, Inc. that they wish to cancel COBRA continuation coverage.
- A qualified beneficiary participates in activity which would otherwise allow the Plan to terminate an active employee's coverage (e.g. submission of a fraudulent claim).

It is important that you notify State of Ohio and iTEDIUM, Inc. of any address change or change in marital status as soon as possible. Failure on your part to do so will result in delayed COBRA notifications or a loss of continuation coverage options. You must also notify iTEDIUM, Inc. within 30 days of other group health coverage, Medicare entitlement or the termination of your Social Security disability status. COBRA continuation coverage which is provided improperly due to your failure to provide notice does not bind the Plan to provide further coverage.

For More Information

For more information on general Plan terms, contact State of Ohio. For more information about COBRA, contact iTEDIUM, Inc. toll free at (877) 682-6272. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit HealthCare.gov.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your state for more information on eligibility –

ALABAMA - Medicaid

Web: <http://myalhipp.com>
Phone: 1-855-692-5447

ALASKA - Medicaid

The AK Health Insurance Premium Payment Program

Web: <http://myakhipp.com>
Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility:

http://dhss.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx

ARKANSAS - Medicaid

Web: <http://myarhipp.com>
Phone: 1-855-MyARHIPP (855-692-7447)

FLORIDA - Medicaid

Web: <http://flmedicaidplrecovery.com/hipp>
Phone: 1-877-357-3268

GEORGIA - Medicaid

Medicaid Website: www.medicaid.georgia.gov
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA - Medicaid

Healthy Indiana Plan for low-income adults 19-64

Web: www.in.gov/fssa/hip
Phone: 1-877-438-4479

All other Medicaid

Web: www.indianamedicaid.com
Phone 1-800-403-0864

IOWA - Medicaid

Web: <https://dhs.iowa.gov/hawki>
Phone: 1-800-257-8563

KANSAS - Medicaid

Web: <http://www.kdheks.gov/hcf>
Phone: 1-785-296-3512

KENTUCKY - Medicaid

Web: <https://chfs.ky.gov>
Phone: 1-800-635-2570

LOUISIANA - Medicaid

Web: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>
Phone: 1-888-695-2447

MAINE - Medicaid

Web: www.maine.gov/dhhs/ofi/publicassistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS - Medicaid and CHIP

Web: www.mass.gov/eohhs/gov/departments/masshealth
Phone: 1-800-862-4840

MINNESOTA - Medicaid

Web: <https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
Phone: 1-800-657-3739 or 651-431-2670

MISSOURI - Medicaid

Web: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA - Medicaid

Web: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084

NEBRASKA - Medicaid

Web: www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA - Medicaid

Medicaid Website: <http://dhcfp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - MedicaidWeb: www.dhhs.nh.gov/oii/hipp.htm

Phone: 603-271-5218

Toll-Free: 1-800-852-3345, ext 5218

NEW JERSEY - Medicaid and CHIP

Medicaid Website:

www.state.nj.us/humanservicesdmahs/clients/medicaid

Medicaid Phone: 609-631-2392

CHIP Website: www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710

NEW YORK - MedicaidWeb: www.health.ny.gov/health_care/medicaid

Phone: 1-800-541-2831

NORTH CAROLINA - MedicaidWeb: <https://dma.ncdhhs.gov>

Phone: 919-855-4100

OKLAHOMA - Medicaid and CHIPWeb: www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON - Medicaid and CHIPWeb: <http://healthcare.oregon.gov/Pages/index.aspx>Web: www.oregonhealthcare.gov/index-es.html

Phone: 1-800-699-9075

PENNSYLVANIA - MedicaidWeb: www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm

Phone: 1-800-692-7462

RHODE ISLAND - MedicaidWeb: <http://www.eohhs.ri.gov>

Phone: 855-697-4347

SOUTH CAROLINA - MedicaidWeb: www.scdhhs.gov

Phone: 1-888-549-0820

SOUTH DAKOTA - MedicaidWeb: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS - MedicaidWeb: <http://gethipptexas.com>

Phone: 1-800-440-0493

UTAH - Medicaid and CHIPMedicaid Website: <https://medicaid.utah.gov>CHIP Website: <http://health.utah.gov/chip>

Phone: 1-877-543-7669

VERMONT - MedicaidWeb: www.greenmountaincare.org

Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP

Medicaid Website:

www.coverva.org/programs_premium_assistance.cfm

Medicaid Phone: 1-800-432-5924

CHIP Website:

www.coverva.org/programs_premium_assistance.cfm

CHIP Phone: 1-855-242-8282

WASHINGTON - MedicaidWeb: www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program

Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA - MedicaidWeb: <http://mywvhipp.com>

Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIPWeb: www.dhs.wisconsin.gov/publications/p1/p10095.pdf

Phone: 1-800-362-3002

WYOMING - MedicaidWeb: <https://health.wyo.gov/healthcarefin/medicaid>

Phone: 307-777-7531

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565