



Pathways to Benefits



OPEN ENROLLMENT

APRIL 25 to MAY 16, 2011

OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES + THE JOINT HEALTH CARE COMMITTEE
SPRING 2011



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myBENEFITS SPRING 2011

YOUR PATH TO WELLNESS



Welcome to the spring edition of *Pathways to myBenefits*. We've expanded the name from *Pathways* to emphasize that the mission of the magazine is to help you better understand your health care benefits.

This edition focuses on the benefits Open Enrollment period being held April 25 through May 16. Any eligible employees who currently are not enrolled or who need to make changes to medical, dental, vision, supplemental life or dependent coverage can do so during Open Enrollment.

Another highlight is information about the incentives available for this coming benefit year through the state's *Take Charge! Live Well!* health and wellness program. Employees and their enrolled spouses may each earn \$100 by completing a health assessment and biometric screening. Based on biometric results, claims data or health assessment results, qualified employees and spouses may each earn up to \$100 more by participating in coaching sessions regarding weight management, disease management or tobacco cessation.

Contents

Welcome to myBenefits Open Enrollment	4	Dental, Vision, Life Insurance Benefits.....	14
Benefits Changes for 2011 - 2012	4	Benefits Enrollment Instructions	17
Eligibility for Benefits	5	Contacts.....	18
Your Medical Coverage	6	Glossary.....	19
<i>Take Charge! Live Well!</i>	10	Legal Notices	19
Your Prescription Drug Benefits.....	12	2011 At A Glance	23
Behavioral Health Benefits	13		

welcome to... myBenefits Open Enrollment

This year's Open Enrollment period has been expanded to three weeks, from April 25 to May 16, to provide employees with additional time to evaluate and research the benefits changes effective July 1, 2011. 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 benefit year, which begins July 1. You will be placed in the Ohio Med PPO plan and assigned a third-party administrator, Medical Mutual or United Healthcare, based on your home ZIP code. Your other coverage, such as dental, vision and supplemental life, will remain the same unless you elect to make changes.

Any eligible employees who currently are not enrolled or who need to make changes to medical, dental, vision, supplemental life and dependent coverage can do so during Open Enrollment, which is being held from Monday, April 25 through Monday, May 16.

Dependents who are enrolled in your medical, dental and vision plans should be reviewed during Open Enrollment. This is an opportunity

to ensure that they still meet the eligibility requirements of a dependent. See the requirements at: das.ohio.gov/eligibilityrequirements.

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 qualifying life event, such as marriage, divorce or the birth or adoption of a child. For a list of qualifying events, go to: das.ohio.gov/qualifyingevents.

Starting on Page 17, you will find enrollment instructions, contact information, a glossary of common benefits terms and required legal notices related to your benefits.

WHAT'S NEW?

The chart below provides a summary of the key changes for the next benefit year.

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

CHANGES FOR THE 2011-2012 BENEFITS PLAN YEAR

Third-Party Administrator (TPA) change	All employees electing coverage will be enrolled in the Ohio Med PPO plan. Check the ZIP code chart on Page 6 to see your assigned plan administrator.
Patient Protection and Affordable Care Act (Federal Health Care Reform)	Extended Dependent Coverage - Federal health care reform provides that all dependent children younger than age 26 may be covered under their parent's health care coverage. Please see chart on Page 5 for additional clarification of requirements and changes.
	Extended Enrollment Period - Employees may request enrollment for children younger than age 26 from April 25 through May 25 for coverage effective July 1.
	Extended Preventive Benefits - <ul style="list-style-type: none"> • See Page 9 for a list of free exams, screenings and immunizations. • See Page 12 for preventive medications covered at no charge. Please refer to: healthcare.gov/law/about/provisions/services/lists.html for the expanded list of all covered benefits.
Medical rates	Lifetime Maximum - There are no longer lifetime maximum limits for health coverage.
	Employee deductions beginning the pay period that includes July 1 can be found on Page 8.



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

¹Certain 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 documentation 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 3. The final deadline to submit all required documentation is July 29.

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 below for further guidance:

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

¹View detailed eligibility and documentation requirements at: das.ohio.gov/eligibilityrequirements.

²View 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 the federal COBRA Act if you notify your agency benefits specialist (or human resources office) within 60 days after the qualifying event occurs. Enrollment or continuation of an ineligible dependent may result in loss of benefits, disciplinary action and/or repayment of claims.

Your Medical Coverage

As part of ongoing efforts to curb health care costs while retaining quality, the State of Ohio will offer one medical plan, the Ohio Med PPO plan, to employees and their dependents beginning July 1.

The state has contracted with Medical Mutual and UnitedHealthcare (UHC) to serve as the third-party administrators for this plan. This change will allow all employees to have access to both network and non-network providers. The PPO plan design includes several enhancements to current HMO benefits, such as unlimited visits for chiropractic services. Please see the chart on Page 7 for more information.

When you are enrolled in medical coverage, you automatically gain the prescription drug, behavioral health and *Take Charge! Live Well!* benefits.

Medical Mutual and UHC will each serve a specific region in Ohio based upon home ZIP codes. **The administrator you will be 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 will be enrolled in UHC.

APPEALS ON THIRD-PARTY ADMINISTRATOR ASSIGNMENT

To minimize potential disruptions in the medical care of employees and their dependents during the transition to the new third-party administrator, a one-time appeal is available to employees and their dependents to remain with their current doctors if certain requirements are met.

Detailed information on the requirements for these appeals can be found on the Benefits Administration website at: das.ohio.gov/TPAappeals.

For answers to frequently asked questions about the assignment of your Ohio Med PPO third-party administrator, please visit the Benefits Administration website at: das.ohio.gov/benefits.

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

434xx	435xx	436xx	440xx	441xx	442xx	443xx
446xx	447xx	448xx	449xx	456xx	457xx	458xx

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 the benefits wisely. Do your part by staying healthy, evaluating your options when you need care and avoid unnecessary care.



OHIO MED PPO (Bold denotes an improvement from the HMO plan design.)

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	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network. Unlimited visits.
Diagnostic, X-Ray and Lab Services	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Durable Medical Equipment	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Emergency Room	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network. Exams and follow-ups are included in coverage. No lifetime maximum.
Home Health Care	<ul style="list-style-type: none"> Covered at 80% network; 60% out of network; limit of 100 visits or 180 days.
Hospice Services	<ul style="list-style-type: none"> Covered at 100% with no copay, time or dollar limitations. For both in and out of network.
Immunizations	<ul style="list-style-type: none"> Most are covered at 100% (see Page 9). For both in and out of network.
Infertility Testing	<ul style="list-style-type: none"> Covered at 80% after \$20 copay, for in network; 60% and \$30 copay out of network. Coverage includes testing only.
Inpatient and Outpatient Services	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Maternity - Delivery	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Maternity - Prenatal Care	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network. Unlimited visits.
Preventive Exams & Screenings	<ul style="list-style-type: none"> Most preventive care covered at 100% (see Preventive Care chart on Page 9). Age restrictions may apply.
Skilled Nursing Facility	<ul style="list-style-type: none"> Covered at 80%; 180-day limit, additional days covered at 60%, for both in and out of network.
Urgent Care	<ul style="list-style-type: none"> \$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's benefit allowance and you pay any remaining balance.

² If your non-network provider 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	\$31.20	\$175.76	\$206.96	\$70.20	\$395.45	\$465.65
Family Minus Spouse	\$85.41	\$482.95	\$568.36	\$192.17	\$1,086.63	\$1,278.80
Family Plus Spouse ¹	\$90.97	\$482.95	\$573.92	\$204.67	\$1,086.63	\$1,291.30

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.

Since the Ohio Med PPO is offered to all employees, there is no longer a component in the medical deductions for the difference in administrative fees.

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	\$51.85	\$155.11	\$206.96	\$103.48	\$103.48	\$206.96
Family Minus Spouse	\$142.20	\$426.16	\$568.36	\$284.18	\$284.18	\$568.36
Family Plus Spouse ¹	\$147.76	\$426.16	\$573.92	\$289.74	\$284.18	\$573.92

PART-TIME BIWEEKLY DEDUCTIONS² 0% TIER

	Employee Share	State Share	Total
Single	\$206.96	\$0.00	\$206.96
Family Minus Spouse	\$568.36	\$0.00	\$568.36
Family Plus Spouse ¹	\$573.92	\$0.00	\$573.92

ADDITIONAL RATES FOR EACH HB1 DEPENDENT (FOR ALL ENROLLED EMPLOYEES)

Biweekly Deduction Amount:	\$85.43
Monthly Deduction Amount:	\$192.22

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.

Since the Ohio Med PPO is offered to all employees, there is no longer a component in the medical deductions for the difference in administrative fees.

Preventive Care Screening – 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 (PCP).

Your State of Ohio health plan – Ohio Med PPO – offers the following services with no deductible, no copayment and no

coinsurance. Other services are available for the normal copayment, coinsurance and deductible amounts.

Please note: Bold items in the charts below are newly covered beginning July 1.

FREE EXAMS AND SCREENINGS	
Bold text indicates newly covered exams/screenings beginning July 1	
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
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	
Bold text indicates newly covered immunizations beginning July 1	
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 females age 9 through 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 adult susceptible
Zoster (shingles)	1 dose for age 19 +

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.

Take Charge! Live Well!

Beginning July 1, employees have the potential to earn more rewards for taking actions regarding their health. When you and your spouse are enrolled in State of Ohio medical coverage you are automatically enrolled in the *Take Charge! Live Well!* (TCLW) health and wellness program.

Taking responsibility for your health and staying healthy is the best strategy for keeping health care costs at a reasonable level.

The *Take Charge! Live Well!* program is administered by APS Healthcare. For more information or to speak with a health coach, visit the program website at: ohio.gov/tclw or call 1.866.272.5507.

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HEALTH ASSESSMENT – EARN \$25

Complete the 15-minute health risk questionnaire at: ohio.gov/tclw by Nov. 30 and earn \$25. You will receive a customized report based on your responses.

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We also offer several worksite screenings each year throughout the state. For a list of worksite screenings close to you, please visit the worksite event calendar on the *Take Charge! Live Well!* website at: ohio.gov/tclw for dates.

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BIOMETRIC SCREENING – EARN UP TO \$75

What is a biometric screening?

A biometric screening is a quick blood test that checks your total cholesterol, HDL level, blood glucose level, blood pressure and body mass index (BMI). These results can give you and your doctor a snapshot of your health and identify any health risks.

You can complete a biometric screening in two ways: you can get a screening from your doctor during an annual physical or at a worksite *Take Charge! Live Well!* road show.

In order to complete the biometric screening through your doctor's office, please go to: ohio.gov/tclw and print the Biometrics Physician Form. Give your doctor the form at your next physical exam and ask them to complete it with your test results.

If you or your spouse qualifies, you can each earn up to an additional \$100 for participation in one of the targeted health coaching programs.

To get started, contact APS Healthcare at 1.866.272.5507 to sign up.

What should I expect?

Your first call with a health coach will take approximately 30 minutes. The health coach will give you a brief overview of the program, followed by a general assessment and education, and then you and your coach will set goals. After you complete the initial health coaching call, you will earn a \$25 incentive.

If you complete three additional calls with a health coach (approximately 20 minutes each), you can earn another \$75.

Please note: Incentives no longer will be offered for online lifestyle programs and health and wellness coaching.



Take Charge! Live Well!

Everyone can earn \$100

Health Assessment	Completed by Nov. 30, 2011	\$25
Biometric Screening	Completed by June 30, 2012	\$75

Complete a health assessment or biometric screening and earn an additional \$100 when identified for one of the following programs:

	1st Coaching Call	4th Coaching Call completed by June 30, 2012
Tobacco Cessation*	\$25	\$75
Weight Management*	\$25	\$75
Disease Management*	\$25	\$75

*APS Healthcare will identify eligible employees and spouses based on biometric screening results, claims experience or health assessment results for these programs. For questions on whether you qualify, contact APS Healthcare at 1.866.272.5507.



WEIGHT MANAGEMENT COACHING – EARN UP TO \$100

If you or your spouse's biometric screening or health care claims indicate that you have a Body Mass Index (BMI) of 30 or more, you are eligible to participate in weight management coaching.

What is BMI? It is a calculation based on your height and weight that can indicate your health risk. Research consistently shows that overweight people are at greater risk for several diseases. Use this program to get started!

TOBACCO CESSATION COACHING – EARN UP TO \$100

If you or your spouse use tobacco and are ready to work on quitting, you can earn up to \$100 for working with a health coach. Use of nicotine replacement therapy or prescription drugs along with counseling can significantly increase your chances of quitting. For additional information on covered nicotine pharmaceuticals, please visit: ohio.gov/tclw.

Beginning July 1, participants in tobacco cessation coaching will be eligible for free nicotine pharmaceuticals.



DISEASE MANAGEMENT COACHING – EARN UP TO \$100

If you have been diagnosed with diabetes, congestive heart failure, coronary artery disease, asthma or chronic obstructive pulmonary disease, you are eligible to participate in a disease management program.

What is disease management? Whether you are newly diagnosed or have lived with a condition for years, this program can help empower you to take charge of your health. Registered nurses can help you better understand your condition, understand medications and treatments that you have been prescribed and help you with any additional conditions you may have.

If you are actively working with an APS Healthcare health coach, you are eligible to receive free diabetic medications and supplies. Contact APS Healthcare at 1.866.272.5507 for additional information.

Your Prescription Drug Benefits

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 Immediate Pharmaceutical Services (IPS) mail-order pharmacy will save you money on your copayments.

90-DAY AT RETAIL PROGRAM

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

PREVENTIVE MEDICATIONS COVERED AT NO CHARGE WITH A PRESCRIPTION EFFECTIVE JULY 1*

Federal health care reform requires that certain preventive medications and treatments be covered at no charge effective July 1. These include:

- Generic aspirin to prevent heart disease for men and women age 45 or older; 1 per day; generic only; requires prescription.
- Fluoride solution or tablets for children younger than the age of 5. Prescription products only.
- Over-the-counter folic acid supplements for women age 55 or younger; 1 per day; requires prescription.
- Iron supplements for children up to 12 months old; requires prescription.

**You must present your Catalyst Rx card to take advantage of these no-cost medications.*

SPECIALTY DRUG MANAGEMENT PROGRAM

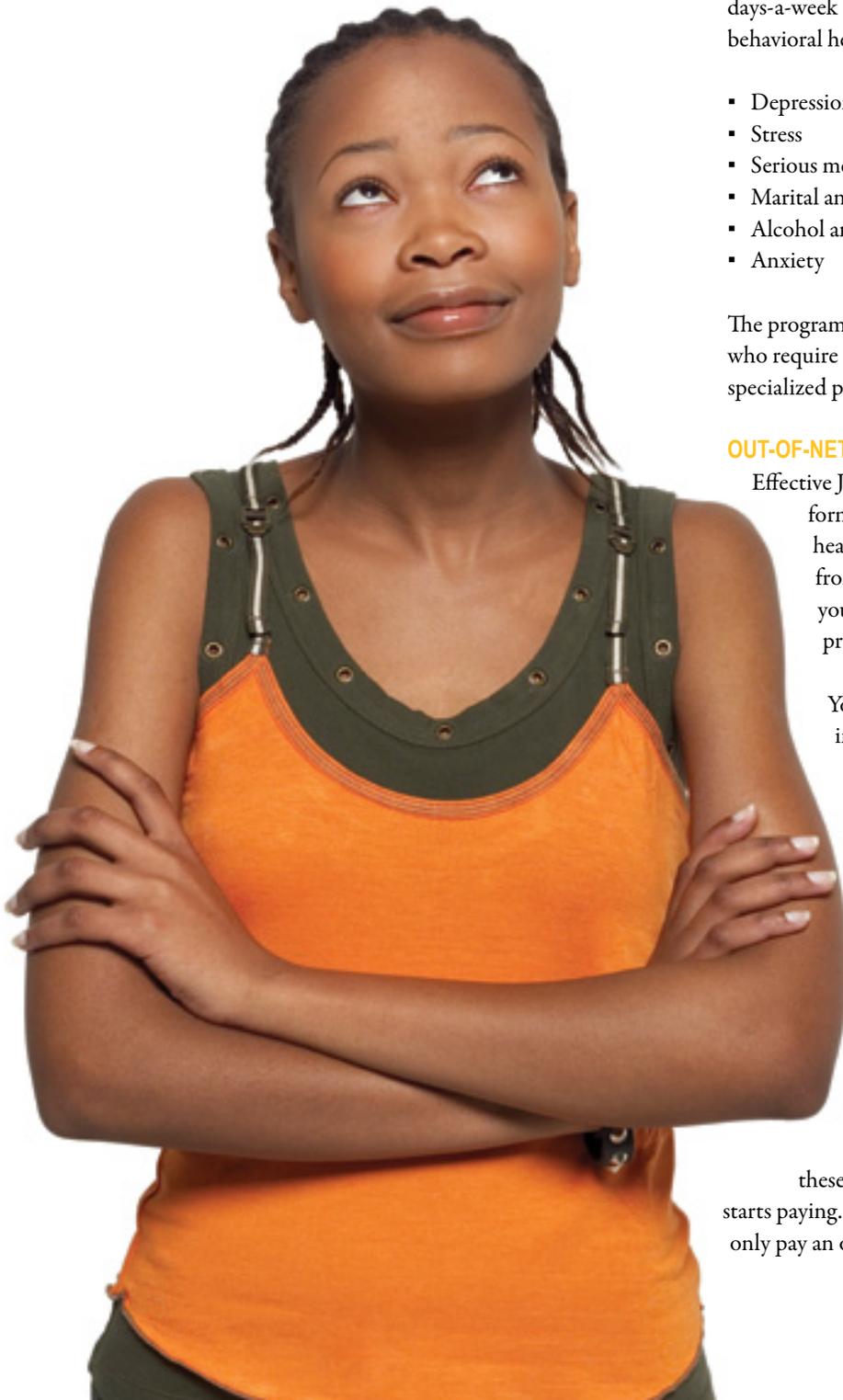
Some specialized medications for serious medical conditions such as cancer, cystic fibrosis and rheumatoid arthritis must be obtained from Walgreens Specialty Pharmacy after your first fill. Your order may be shipped to your home, workplace or a local Walgreens for pickup. A description of the program 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 heartburn medications, drugs used for migraines, osteoporosis, nasal allergies, sleep disturbances, high blood pressure, 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 Benefits



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 telephonic 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.

OUT-OF-NETWORK BENEFITS

Effective July 1, all enrolled employees and their families, including former HMO enrollees, will 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.

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

Inpatient services will be 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.

Copayments, deductibles and coinsurance must be shared and combined with your medical plan pursuant to federal mental health parity requirements. 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.

Exempt Dental, Vision and Life Insurance Benefits

The state pays the full cost for you and your eligible dependents (children younger than age 23) to participate in the dental and vision plans. The state also pays the full cost for you to participate in the basic life plan. 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 15 to view a plan comparison chart or Page 18 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 15 to view a plan comparison chart or Page 18 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 18 for plan contact information.

EXEMPT BASIC LIFE INSURANCE (Through The Standard)

The State of Ohio provides basic life insurance, including an accidental death and dismemberment benefit for work-related injuries, free of charge to all eligible exempt employees who have one year of continuous state service. This benefit is equal to one times your annual

salary rounded to the nearest \$1,000, is provided at no cost to you, and enrollment is automatic.

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 annual rate (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. Turn to Page 16 for the imputed income rate table.

EXEMPT SUPPLEMENTAL LIFE INSURANCE (Through Prudential)

Exempt employees are eligible for supplemental life insurance coverage. When you enroll in supplemental life insurance coverage, you also may elect life insurance for your eligible dependents. The amount you contribute toward your supplemental and dependent life coverage is deducted from your paycheck.

For Yourself

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

For Your Spouse

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

For Your Dependent Children

You may purchase \$7,000 of life coverage for each of your eligible dependent children younger than age 23 at a rate of \$0.99 cents per month regardless of how many children you cover. You are responsible for dropping your dependent's coverage when your child reaches age 23.

See Page 16 for the rate chart.

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 Benefits Administration website at: das.ohio.gov/healthcareforms.

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 week of April 18. The guide includes enrollment/change forms for dental, vision and legal plans. A separate "Supplemental Life Enrollment Kit" from Prudential will arrive during the same period and will include information on supplemental life, rates and an enrollment form.

EXEMPT 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

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		You pay \$15 copay, then plan pays maximum benefit of:		Plan reimburses a maximum benefit of:
Single Vision Lenses	Plan pays 100% after \$15 copay.	\$25	Plan pays 100%.	\$25
Bifocal Lenses		\$35		\$35
Progressive Lenses		\$52		\$55
Trifocal Lenses		\$52		\$52
Lenticular Lenses		\$62		\$62
Polycarbonate Lenses		\$0		\$0
(Available to All)				
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)	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 reimburses a maximum of \$105 plus standard eye exam.
Medically Necessary	Plan pays 100% plus standard eye exam.	Plan pays maximum of \$125 plus standard eye exam.	Plan pays 100% plus standard eye exam.	Plan reimburses a maximum of \$105 plus standard eye exam.

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, 2011	NON-SMOKER	SMOKER
29 and Younger	\$0.59	\$0.78
30 through 34	\$0.72	\$0.78
35 through 39	\$0.82	\$1.14
40 through 44	\$1.30	\$1.76
45 through 49	\$2.01	\$2.92
50 through 54	\$3.13	\$4.50
55 through 59	\$5.02	\$6.69
60 through 64	\$7.61	\$10.26
65 through 69	\$12.36	\$18.41
70 and Older	\$20.94	\$32.95



Benefits Enrollment Instructions

Employees who currently have medical coverage and whose plan is changing will automatically be enrolled into their assigned administrator. In addition, current HB1 children younger than age 26 will be automatically changed from HB1 status to dependent status and will be included in your family coverage. 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 your benefits by carefully reading this Open Enrollment edition of *Pathways to myBenefits*. If you have questions, contact your agency benefits representative (or 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 through Self Service at: myOhio.gov or by using a paper enrollment and change form available from your agency benefits representative.



A. **ONLINE** – Go to: myOhio.gov to access Self Service for benefits.

- Enter your Employee ID number and password.
If you have forgotten your Employee ID number or your password, contact HR Customer Service by e-mail at: HRcustomerservice@das.state.oh.us or call toll-free, 1.800.409.1205, or in Columbus, 614.466.8857.
- Click on Self Service.
- Click on **Benefits > Benefits Summary > 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 April 25 to May 16, 2011, 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

Obtain a paper Medical Benefit Enrollment and Change Form (ADM 4717) and/or a Dental and Vision Enrollment and Change Form for exempt employees (ADM 4720) from your agency's human resources office. Or you may access these forms online. The forms are accessible online by clicking on the 2011 Open Enrollment link located on the following state web pages: The State Employee drop-down menu on the ohio.gov website, the DAS home page at: das.ohio.gov and the Benefits Administration website at: das.ohio.gov/benefits.

3. Submit your enrollment or changes:

A. **ONLINE** – Make and submit your selections through Self Service at: myOhio.gov by Monday, May 16. 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 Medical and/or Dental and Vision Enrollment and Change Form to your agency's human resources office by 4 p.m. Monday, May 16.

Under the new requirements of federal health care reform, employees may request enrollment for children up to age 26 during an extended open enrollment period between April 25 and May 25, 2011. Enrollment will be effective July 1, 2011. If you are enrolling one of these dependents after May 16 you will have to use an enrollment form and submit it to your agency's benefits representative. This applies to medical benefits only. All other changes must be submitted by May 16.

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

IMPORTANT:

If you are enrolling for the first time and are covering dependents, or if you are 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 29.

Health and Other Benefits Contacts

MEDICAL

MEDICAL MUTUAL

1.800.822.1152
mmob.com
Group Number: 228000201

UNITED HEALTHCARE

1.877.440.5977
myuhc.com
Group Number: 702097

PRESCRIPTION DRUG

CATALYST RX

1.866.854.8850
catalystrx.com

BEHAVIORAL HEALTH & SUBSTANCE ABUSE

UNITED BEHAVIORAL HEALTH

1.800.852.1091
liveandworkwell.com
Group Number: 00832
Code: 00832

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 ACCOUNT

FRINGE BENEFITS MANAGEMENT COMPANY (FBMC)

1.800.342.8017
myfbmc.com

OTHER BENEFITS – EXEMPT EMPLOYEES

DELTA DENTAL OF OHIO

1.800.524.0149
deltadentaloh.com
Group Number: 9273-0001 (PPO)
Group Number: 9273-1001 (Premier)

VISION SERVICE PLAN (VSP)

1.800.877.7195
vsp.com
Group Number: 12022518

EYEMED VISION CARE

1.866.723.0514
eyemedvisioncare.com
Group Number: 9676008

BASIC LIFE INSURANCE

The Standard
1.866.415.9518
standard.com/mybenefits/ohio

SUPPLEMENTAL LIFE INSURANCE

Prudential Life Insurance
1.800.778.3827
Group Number: LG-93046

OTHER CONTACTS

OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES

HR Customer Service
614.466.8857
1.800.409.1205
e-mail: HRCustomerService@das.state.oh.us
das.ohio.gov/benefits

UNION BENEFITS TRUST

614.508.2255
1.800.228.5088
benefitstrust.org

LONG TERM CARE INSURANCE (EXEMPT AND UNION-REPRESENTED)

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

BARGAINING UNIT CONTACT NUMBERS

VISION SERVICE PLAN

1.800.877.7195
Group Number: 12022914

EYEMED VISION CARE

1.866.723.0514
Group Number: 9674813

DELTA DENTAL OF OHIO

1.877.334.5008
Group Number: 1009

PRUDENTIAL LIFE INSURANCE

1.800.778.3827
Group Number: LG-01049

WORKING SOLUTIONS PROGRAM

1.800.358.8515
Group Number: 4718

HYATT LEGAL SERVICES

1.800.821.6400
Group Number: 49000010

UNION BENEFITS TRUST (UBT)

614.508.2255
1.800.228.5088
Union-represented employees can access
plan information at: *benefitstrust.org*

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

- Group Number
- Employee ID Number
- Explanation of Benefits (EOB) if call is regarding claims.

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.

HEALTH MAINTENANCE ORGANIZATION (HMO): A plan for comprehensive health services prepaid by an individual or by a company for its employees that provides treatment, preventive care and hospitalization to each participating member within a specific network.

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 without assuming any risk.

LEGAL NOTICES

Continuation Coverage Rights Under COBRA

INTRODUCTION

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

The parent-employee dies;
The parent-employee's employment ends for any reason other than his or her gross misconduct;

LEGAL NOTICES

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
Benefits Administration Services
30 E. Broad Street, 27th Floor
Columbus, OH 43215
614.466.8857 or 1.800.409.1205

Women's Health and Cancer Rights

Act of 1998: Notice of Rights

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

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

1. all stages of reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

If you have any questions about the State of Ohio's plans provisions relating to the Women's Health and Breast Cancer Rights Act of 1998, contact 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).

Coverage for Dependents to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Ohio Med PPO. Individuals may request enrollment for such children during a special open enrollment period between April 25 through May 25, 2011. Enrollment will be effective July 1, 2011. For more information, contact HR Customer Service at 1.800.409.1205.

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, 2011, to June 30, 2012, 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.

LEGAL NOTICES

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 Nov. 15 through Dec. 31. 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 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 PRESCRIPTION DRUG COVERAGE...

Contact the person listed below for further information.

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, 2011

STATE OF OHIO
DAS Benefits Administration
Prescription Drug Benefits Manager
30 East Broad, 27th Floor
Columbus, OH 43215
1.800.409.1205

2011 AT A GLANCE

APRIL

- Prepare for Benefits Open Enrollment by updating your personal data via Self Service at: myOhio.gov
- Benefits Open Enrollment begins April 25

MAY

- Benefits Open Enrollment ends May 16
- Healthy Ohio Fitness Walk, May 18
- National Public Employee Health and Fitness Month

JUNE

- *Take Charge! Live Well!* (TCLW) year ends June 30
- Annual exams for children

JULY

- New benefits year begins July 1

AUGUST

- Dental Health Month

SEPTEMBER

- Get a flu shot
- National Cholesterol Education Month

OCTOBER

- Flexible Spending Account (FSA) Open Enrollment
- Breast Cancer Awareness Month
- National Depression Screening Month

NOVEMBER

- TCLW assessments must be completed by Nov. 30
- National Diabetes Month

DECEMBER

- Use your remaining FSA money

Human Resources Division
Benefits Administration Services

30 E. Broad St., 27th Floor
Columbus, Ohio 43215

