Pathways to Benefits

2013 Open Enrollment
May 6-20
2013 Benefits Overview

Welcome to the 2013 Open Enrollment edition of Pathways to myBenefits magazine. The purpose of this edition is to inform you and your family about the State of Ohio’s employee health care benefits available this coming benefit year, which begins July 1.

Eligible employees can elect to enroll themselves and/or their dependents in medical, dental and vision coverage during the Open Enrollment period, which is being held Monday, May 6 through Monday, May 20. If you wish to waive coverage, you will need to opt out of coverage during Open Enrollment.

For exempt employees, a separate Open Enrollment period will be held for the supplemental life plan. Exempt employees will receive information at a later date. For union-represented employees, enrollment for the supplemental life plan will continue to be held during the Open Enrollment period.

If you already are enrolled in benefits, verify that your benefits-related information on myOhio.gov is correct for you and your dependents. Ensure dependents still meet the eligibility requirements by visiting das.ohio.gov/eligibilityrequirements.

All current and new enrollees should be aware of the changes below.

CHANGES FOR THE UPCOMING BENEFIT YEAR

• Dental and vision plans for exempt employees—The state is consolidating plans by eliminating the following plans with low enrollment: Delta Dental Premier and EyeMed Vision Care. As a result, current enrollees who wish to maintain dental coverage will be enrolled automatically in the Delta Dental PPO without taking any action. Likewise, current enrollees who wish to maintain vision coverage will be enrolled automatically in the Vision Service Plan (VSP) without taking any action. However, current enrollees who wish to waive coverage will need to dis-enroll during the Open Enrollment period. (see Page 14);

• Dental annual maximum limit – The annual maximum limit for all in-network and out-of-network dental work will be $1,500. (see Page 15);

• 100 percent coverage – Complete coverage for support, supplies and counseling for breast-feeding mothers (see Page 7);

• Long-Term Care Insurance – The Prudential Insurance Company of America is not accepting new enrollments after June 30, 2013. Current enrollees can continue to stay on the plan. (see Page 13);

• Summary of Benefits and Coverage: The federal Affordable Care Act requires this concise four-page summary document detailing simple and consistent information about your health plan benefits and coverage. For the State of Ohio’s Summary of Benefits and Coverage, visit the Benefits Administration website at das.ohio.gov/bc. For a printed copy of the summary, see your agency benefits representative.

• Autism coverage – Information will be provided at a later date.
Benefits Enrollment Instructions

If you are not currently enrolled in coverage or you want to add or remove a dependent from your current coverage, please follow the steps below:

1. Review information about available benefits by carefully reading this Open Enrollment edition of Pathways to myBenefits. If you have questions, contact your agency benefits representative, human resources office or the Ohio Department of Administrative Services’ HR Customer Service desk at 1-800-409-1205.

2. Enroll in coverage or make changes to your dependents’ current coverage, please follow the steps below:

   a. Review information about available benefits by carefully reading this Open Enrollment edition of Pathways to myBenefits. If you have questions, contact your agency benefits representative, human resources office or the Ohio Department of Administrative Services’ HR Customer Service desk at 1-800-409-1205.

   b. Go to: myOhio.gov.

   c. Enter your Employee ID number and password.

   d. If you have forgotten your Employee ID number or your password, contact HR Customer Service by calling toll-free, 1-800-409-1205, or in Columbus, 614-466-8857. Make sure to select Option 1 when prompted;

   e. Click on myBenefits under Self Service Quick Access on the right side of the page.

   f. The Benefits Summary page will open;

   g. Click on Enroll in Benefits.

   h. For detailed instructions on how to enroll or make changes online, go to:

      das.ohio.gov/enrollmentinstructions.

   i. Online Open Enrollment is available May 6 to 20, 2013, 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

   j. If you are enrolling for the first time and/or adding new dependents during this Open Enrollment, you must provide the required eligibility documentation for your dependents. A listing of the required documentation can be found at:

      das.ohio.gov/eligibilityrequirements.

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

   l. If  you are enrolling for the first time and/or adding new dependents during this Open Enrollment, you must provide the required eligibility documentation for your dependents. A listing of the required documentation can be found at:

      das.ohio.gov/eligibilityrequirements.

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

Enrollment Eligibility

Any eligible employees who currently are not enrolled or who need to make changes to medical, dental and vision can do so during Open Enrollment, held from Monday, May 6 through Monday, May 20. For exempt employees, Open Enrollment for supplemental life coverage will be held at a later date. Exempt employees will receive information later. For employees represented by a bargaining unit, enrollment for the supplemental life plan will continue to be held during the Open Enrollment period.

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

For more information about qualifying events:

1. Go to: das.ohio.gov/benefits.

2. Click on the link for the Change In Status/Qualifying Events Matrix along the right navigation pane.

ELIGIBILITY FOR BENEFITS

EMPLOYEES

- Medical – Most state employees are eligible to enroll in medical coverage (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 – Permanent 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 – Permanent 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 – Permanent exempt and union-represented employees are eligible for coverage on their date of hire and have 90 days to enroll. Union-represented employees also may enroll or make changes during Open Enrollment. This year Open Enrollment for supplemental life coverage for exempt employees will be held at a later date.

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

If you are responsible to contact your agency benefits specialist or human resources office when one of your enrolled dependents is or becomes ineligible for benefits coverage.

PLEASE NOTE: The material in this publication is for informational purposes. It is intended only to highlight the main benefits, eligibility policies and coverage information for State of Ohio employees and their dependents. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the plan documents, the plan documents govern. To locate the plan documents, go to the Benefits Administration website. das.ohio.gov/benefits, click on the MyOhio GO portal located in the right navigation pane under Benefits.
The State of Ohio contracts with Medical Mutual of Ohio and UnitedHealthcare to serve as the third-party administrators for the Ohio Med Preferred Provider Organization (PPO) plan. Under this plan, employees have access to both network and non-network providers. For deduction information, see the charts on Page 8.

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

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

<table>
<thead>
<tr>
<th>DEPENDENT CATEGORY</th>
<th>MEDICAL</th>
<th>DENTAL</th>
<th>VISION</th>
<th>SUPPLEMENTAL LIFE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children younger than age 23</td>
<td>Coverage available for eligible dependents¹</td>
<td>Coverage available for eligible dependents¹</td>
<td>Coverage available for eligible dependents¹</td>
<td>Coverage available for eligible dependents¹</td>
</tr>
<tr>
<td>Children ages 23 - 25</td>
<td>Coverage available for eligible dependents¹</td>
<td>No coverage available</td>
<td>No coverage available</td>
<td>No coverage available</td>
</tr>
<tr>
<td>Children ages 26 - 27</td>
<td>Coverage available for eligible H&amp;B dependents¹</td>
<td>No coverage available</td>
<td>No coverage available</td>
<td>No coverage available</td>
</tr>
</tbody>
</table>

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

Note: When one of your enrolled dependents is or becomes ineligible for benefits coverage based on the state’s definition of eligibility, it is your responsibility to contact your agency benefits specialist (or human resources office) immediately to remove them from your coverage. Your dependent may be eligible to continue their medical, dental and/or vision benefits through COBRA (continuation coverage) if you notify your agency benefits specialist (or human resources office) within 60 days after the qualifying event. Enrollment or continuation of an ineligible dependent may result in loss of benefits, disciplinary action and/or repayment of claims.

To obtain information from your third-party administrator:

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

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, Medical Mutual and UnitedHealthcare review claims and process payments, and are paid an administrative fee. When the amount of claims is greater than the amount of the contributions from employees and agencies, your medical costs go up. It is up to each of us to use our benefits wisely. Please do your part by staying healthy, evaluating your options when you need care and avoiding unnecessary visits.

How You Can Help

Out-of-Pocket Costs

<table>
<thead>
<tr>
<th>OHIO MED PPO</th>
<th>OUT-OF-POCKET COSTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible Network: $200 single, $400 family; out of network: $400 single, $800 family.</td>
<td></td>
</tr>
<tr>
<td>Your Copayments (Office Visits) Network: $20; out of network: $30.</td>
<td></td>
</tr>
<tr>
<td>Coinsurance Network: You pay 20%; plan pays 80%; out of network: You pay 40%; plan pays 60%;¹</td>
<td></td>
</tr>
<tr>
<td>Your Out-of-Pocket Maximum Network: $1,500 single, $3,000 family; out of network: $3,000 single, $6,000 family.²</td>
<td></td>
</tr>
</tbody>
</table>

Benefits/Service

Coverage Levels

- Covered at 80% in network; 60% out of network.
- Unlimited visits.
- Covered at 80% in network; 60% out of network.
- Covered at 80% in network; 60% out of network.
- Covered at 80% in network; 60% out of network.
- Covered at 80%; $75 copay, which is waived if patient is admitted; 60% out of network for non-emergency.
- Covered at 80% in network; 60% out of network.
- Covered at 100% with no copay, time or dollar limitations for both in and out of network.
- Most are covered at 100% in network; 60% out of network.
- Covered at 80%; 180-day limit, additional days covered at 60%, for both in and out of network.
- Covered at 80% in network; 60% out of network.
- Covered at 80% in network; 60% out of network.
- Covered at 80% in network; 60% out of network.
- Covered at 80% in network; 60% out of network.
- Covered at 80%; $25 copay in network; $30 copay out of network.
- Covered at 80% in network; 60% out of network.

Changes are in bold above.

¹Plan pays 60% of Ohio Med PPO’s benefit allowance and you pay any remaining balance.

²If your non-network charge is greater than the Ohio Med PPO allowance, your out-of-pocket costs will be more.
Preventive Care

STAY HEALTHY, SAVE MONEY

Preventing and detecting disease early is important to living a healthy life. The better your health, the lower your health care costs are likely to be. One of the most important actions you can take for your health and your family’s health is to schedule regular check-ups and screenings with your primary care physician.

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

FREE EXAMS AND SCREENINGS

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

FREE IMMUNIZATIONS

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

*HPV immunization is recommended for males and females. Note: This is not an all-inclusive list. For more information about preventive care services, please refer to: Healthcare.gov/law/about/provisions/services/lists.html.

Employee Share | State Share | Total
---|---|---
Clinical breast exam | $67.95 | $433.71 | $501.66
Colonoscopy | $210.45 | $1,190.19 | $1,400.64
Flexible sigmoidoscopy | $323.23 | $1,190.19 | $1,513.42
Glucose | $117.84 | $1,179.84 | $1,297.68
Gynecological Exam | $323.23 | $1,190.19 | $1,513.42
Hemoglobin, hematocrit or CBC | $97.13 | $549.32 | $646.45
Lipid profile or total and HDL cholesterol | $328.99 | $1,190.19 | $1,519.18
Mammogram | $102.90 | $549.32 | $652.22
Pre-natal office visits | $59.04 | $176.64 | $235.68
Prostate-specific Antigen (PSA) | $161.73 | $484.72 | $646.45
Stool for occult blood | $167.50 | $484.72 | $652.22
Urinalysis | $235.68 | $0.00 | $235.68
Well-baby, well-child exam | $101.77 | $0.00 | $101.77
Well-person exam (annual physical) | $220.51 | $0.00 | $220.51

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

Employee Share | State Share | Total
---|---|---
Clinical breast exam | $76.95 | $433.71 | $510.66
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**Prescription Drug**

**Pharmacy Website Offers Online Tracking, Tools**
The website for Catamaran, formerly Catalyst Rx, myCatamaranRx.com, is a private, secure site designed just for you. All of your pharmacy plan information is available at your fingertips 24/7 and kept up-to-date in real time.

Easy access to the Catamaran website allows you to:
- Compare mail-order prices and prices at local pharmacies;
- Find your lowest cost pharmacy;
- Locate your pharmacy and get driving directions;
- Manage your mail-order prescriptions, including options to request a refill or track an order;
- Keep track of your health history;
- Learn more about your prescription drugs;
- Take it all with you through the Catamaran mobile app;

Visit myCatamaranRx.com today. You will need your pharmacy member ID number on your Catamaran/Catalyst Rx card to log in.

For questions, contact Catamaran’s Pharmacy Help Desk at 1.866.854.8850.

**Acne Agents Will Require Approval for Coverage**

Oral antibiotic acne agents will require approval for coverage beginning July 1, 2013. Acne medications affected by the change include:

Medications requiring approval:
- Doxycycline, minocycline or tetracycline.
- Recommended alternative medications:
  - Doryx, Oracea and Solodyn.

If you purchase a medication requiring approval, you will be responsible for 100 percent of the medication’s cost at the pharmacy. To avoid paying the higher cost, you will need to obtain a new prescription for a recommended alternative from your health care provider to ensure coverage of your medication.

Contact your doctor to schedule an appointment and discuss whether this treatment is right for you. At your appointment, discuss the switch to a recommended medication and, if appropriate, obtain a new prescription.

If you have previously tried a recommended medication and it did not work for you, contact Catamaran Member Services at 1.866.854.8850 to inquire about a prior authorization for your current medication. Once authorized, you will pay your plan’s higher non-preferred brand copayment for the medication.

**Behavioral Health**

**Help Available 24/7**

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

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

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

**Benefits**

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

**Behavioral Health Benefit Plan**

<table>
<thead>
<tr>
<th>Copayments</th>
<th>Outpatient office visit in-network</th>
<th>Outpatient office visit out-of-network</th>
<th>Emergency Room</th>
<th>Intensive outpatient care in-network</th>
<th>Intensive outpatient care out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$00</td>
<td>$30; balance billing applies</td>
<td>$75</td>
<td>$20</td>
<td>$30; balance billing applies</td>
</tr>
</tbody>
</table>

**Deductibles**

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>Outpatient in-network</th>
<th>Outpatient out-of-network</th>
<th>Inpatient in-network</th>
<th>Inpatient out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single in-network</td>
<td>$200 combined with medical</td>
<td></td>
<td>$350 penalty if not preauthorized</td>
<td></td>
</tr>
<tr>
<td>Family in-network</td>
<td>$400 combined with medical</td>
<td></td>
<td>$300 penalty if not preauthorized</td>
<td></td>
</tr>
<tr>
<td>Single out-of-network</td>
<td>$400 combined with medical</td>
<td></td>
<td>$300 penalty if not preauthorized</td>
<td></td>
</tr>
<tr>
<td>Family out-of-network</td>
<td>$800 combined with medical</td>
<td></td>
<td>$300 penalty if not preauthorized</td>
<td></td>
</tr>
</tbody>
</table>

**Plan Coinsurance %**

<table>
<thead>
<tr>
<th>Plan Coinsurance %</th>
<th>Outpatient in-network</th>
<th>Outpatient out-of-network</th>
<th>Inpatient in-network</th>
<th>Inpatient out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient in-network</td>
<td>100% after office visit copay, 80% for other services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient out-of-network</td>
<td>60% of fee schedule after copayment; balance billing applies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient in-network</td>
<td>80% after deductible; 350 penalty if not preauthorized</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient out-of-network</td>
<td>60% after deductible; 350 penalty if not preauthorized</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Out-Of-Pocket Maximum**

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single in-network</td>
<td>$1,500 combined with medical</td>
<td>$3,000 combined with medical</td>
<td>$3,000 combined with medical</td>
<td>$6,000 combined with medical</td>
</tr>
<tr>
<td>Family in-network</td>
<td>$3,000 combined with medical</td>
<td>$3,000 combined with medical</td>
<td>$3,000 combined with medical</td>
<td>$6,000 combined with medical</td>
</tr>
<tr>
<td>Single out-of-network</td>
<td>$3,000 combined with medical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family out-of-network</td>
<td>$6,000 combined with medical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Day limits None</td>
<td>Annual limits None</td>
<td>Lifetime limits None</td>
<td>Benefits limits Some</td>
</tr>
</tbody>
</table>

*myBENEFITS SPRING 2013*
More and more, employees are looking to change their lifestyle in an effort to improve their long-term health. Dieting and setting short-term fitness goals, such as running a 5k race, are worthwhile and can help you improve your health. However, adopting a healthier lifestyle is even better.

The chart on this page describes how easy it is to take the necessary steps toward improving your wellness and the incentive for achieving milestones. It all starts with completing your Well-Being Assessment and your biometric screening. Then choose your pathway – either the Online Pathway or the Coaching Pathway (phone calls from a personal health coach) – and you are on your way to a healthier lifestyle.

ENHANCED INCENTIVE PAYMENT METHOD GIVES YOU MORE CHOICES

METhOD gIvES YOu MORE chOIcES

ENhANcED INcENTIvE PAYMENT

health coach) – and you are on your way to a healthier lifestyle.

METhOD gIvES YOu MORE chOIcES

ENhANcED INcENTIvE PAYMENT

health coach) – and you are on your way to a healthier lifestyle.

METhOD gIvES YOu MORE chOIcES

ENhANcED INcENTIvE PAYMENT

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METhOD gIvES YOu MORE chOIcES

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health coach) – and you are on your way to a healthier lifestyle.

METhOD gIvES YOu MORE chOIcES

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health coach) – and you are on your way to a healthier lifestyle.

METhOD gIvES YOu MORE chOIcES

ENhANcED INcENTIvE PAYMENT

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

**CONSOLIDATED PLANS ALLOW FOR ENHANCED BENEFITS**

Due to low enrollment, the State of Ohio is consolidating plans by eliminating two plans for exempt employees, Delta Dental Premier and EyeMed Vision Care, as of July 1.

If you currently are enrolled in one or both of these plans, you do not have to take any action during this upcoming Open Enrollment period because you automatically will be enrolled in the Delta Dental PPO and/or the Vision Service Plan (VSP). However, if you wish to waive coverage, you will need to opt out during the open enrollment period.

This consolidation is allowing the State of Ohio to enhance coverage. For example:

- For the Delta Dental PPO plan, the annual limits for using Delta Premier network and out-of-network dentists are both increasing to $1,500 to match the current Delta Dental Premier plan benefits;
- For vision coverage, VSP provides an enhanced selection of premium polycarbonate lenses and generally lower out-of-pocket costs for frames and lenses compared to the current EyeMed coverage, which ends June 30.

**Delta Dental PPO**

All exempt state employees currently enrolled in the Delta Dental Premier plan automatically will be enrolled in the Delta Dental PPO plan.

The Delta Dental PPO plan provides employees with access to two networks of dentists – the Delta Dental PPO network and the Delta Dental Premier network. In addition, you can go to any licensed dentist of your choice and receive benefits, but you typically will pay less when you go to an in-network dentist.

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

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

deltadentaloh.com
1.800.524.0149

**Vision Plan for Exempt Employees**

All exempt state employees currently enrolled in the EyeMed vision plan automatically will be enrolled in the Vision Service Plan (VSP). Please be aware, your current vision provider may not be a member of the VSP network. Verify your vision provider’s network status with VSP before your next visit. If you choose to use a non-network provider, out-of-network charges will apply.

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

vsp.com
1.800.877.7195

**PRINT YOUR DELTA DENTAL CARD ONLINE**

If you would like a card to present to your dentist, you may print a card from Delta Dental’s website. After you are enrolled in the dental plan, visit: deltadentaloh.com and click on the Consumer Toolkit. Complete the login process and click on Print ID Card. If you are enrolling in the plan for the first time, please wait until July 1 to access the dental site.

**Dental and Vision**

For Exempt Employees

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

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

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

**FOR UNION-REPRESENTED EMPLOYEES**

Union-represented employees receive dental, vision, life and legal plan benefits through Union Benefits Trust (UBT). The UBT Enrollment Guide will be mailed to union members’ homes. The guide includes enrollment/change forms for dental, vision and legal plans. A separate “Supplemental Life Enrollment Kit” from Prudential will arrive during the same period and will include information about supplemental life, rates and an enrollment form.

**PRINT YOUR VSP CARD ONLINE**

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

See the next page to view the in-network and out-of-network benefits for the dental and vision plans.
Health and Other Benefits Contacts

ALL EMPLOYEES

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

UnitedHealthcare 1.877.440.5977 unitedhealthcare.com/ohio Group Number: 700297

Prescription Drug
Catamaran 1.866.854.8850 mycatamaranrx.com Rx Group #: STU3H

Behavioral Health & Substance Abuse
United Behavioral Health 1.800.852.1091 www.unitedhealthcare.com Health Access Code: 008322

Employee Assistance Program
1.800.221.6327 www.oaa.org/collective.aspx

Take Charge! Live Well! Healthways 1.866.536.2288 livewell@healthways.com

24-Hour Nurse Advice Line Healthways 1.866.536.2288, Option 1

Flexible Spending Accounts WageWorks 1.855.428.0446 wageworks.com

Long Term Care Insurance
Prudential Long Term Care Solidsolutions 1.800.322.0416 prudential.com/GTLCWEB Group Name: stateofohio Access Code: buckeyes Group Number: LT-50636-OH (New enrollments accepted through June 30, 2013.)

EXEMPT EMPLOYEES ONLY

Dental
Delta Dental of Ohio 1.800.524.0149 deltadental.com

POPO Plan
Group Number: 9273-0003
Premier Plan
Group Number: 9273-1001
(Delta Dental Premier Plan effective through June 30, 2013.)

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

Eyemed Vision Plan
1.866.723.0514 www.emedvisioncare.com Group Number: 9676008 (Effective through June 30, 2013.)

Life Insurance
Basic Life Insurance
The Standard 1.866.415.9518 standard.com/mybenefits/ohio Group Number: 665571

Supplemental Life Insurance
Prudential Life Insurance 1.800.778.3827 prudential.com/mybenefits Group Number: 930406

UNION-REPRESENTED EMPLOYEES ONLY

Union Benefits Trust
614.508.2255 1.800.228.5088 benefitstrust.com

Dental
Delta Dental of Ohio 1.877.334.5008

Vision
Vision Service Plan 1.800.877.7195 Group Number: 1009

Eyemed Vision Care
1.866.723.0514 www.emedvisioncare.com Group Number: 9674813

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

Work/Life Program
Working Solutions Program 1.800.538.8515 Group Number: 4718

Legal Services
Hyatt Legal Services 1.800.821.6400 Group Number: 4900010

Ohio Department of Administrative Services
HR Customer Service 614.466.8887 / 1.800.409.1205 hrcustomerservice@odag ohio.gov/exchanges/benefits

Legal Notices

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, plan development, data management, communications, claims and operational audits, and legal services. In addition, a health plan may send you information based on your own health information to inform you of possible treatment options or alternatives that may be available to you. The Plan may also combine your health information with that of other enrolled persons to evaluate the coverage provided and the quality of care received.

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

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

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

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

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

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

E. Victims of Abuse, Neglect, or Domestic Violence. The Plan may disclose medical information to a health oversight agency if authorized by law in order to monitor the overall health care system, the conduct of government programs, and compliance with civil rights laws.

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

H. Law Enforcement Purposes. The Plan may release medical information to law enforcement officials for law enforcement purposes including investigation of a crime or to identify or locate a suspect, fugitive, material witness or missing person.
I. Specialized Government Functions. The Plan may release medical information to authorized federal officials for the purposes of intelligence, counterintelligence, and other national security activities authorized by law.

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

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

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

M. Coroners, Medical Examiners, and Funeral Directors. The Plan may release medical information to a coroner or medical examiner, or to a funeral director, 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 parties who assist the Plan are called business associates. At times, the Plan may disclose PHI so they can provide services. The Plan will require that any business associates who receive PHI safeguard the privacy of that information.

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

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

In all situations other than those described previously, the Plan will ask for your written authorization before using or disclosing your PHI. If you have provided authorization, you may revoke it in writing at any time unless the Plan has already disclosed the information.

4. Changes to Existing Laws

Certain provisions of Ohio law may impose greater restrictions on uses and/or disclosures of PHI, or otherwise be more stringent than federal rules protecting the privacy of PHI. If such provisions of Ohio law apply to a use or disclosure of PHI 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 requested 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 information to 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 any routine disclosures including, but not limited to, those made to you or pursuant to your authorization, those made for treatment, payment and operations purposes as discussed above, those made for national security and intelligence purposes, and those made to law enforcement in compliance with law.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan’s HIPAA Privacy Contact listed below. Your request must state the time period that may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (paper or electronic). The first list you request within a 12-month period will be free. For additional

lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice even if you have received it electronically. You may make your request to the Plan’s HIPAA Privacy Contact listed below. The Plan will post a copy of the current notice at das.ohio.gov/benefits.

This Notice is Subject to Change

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

Whom to Contact

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

To file a complaint with the Secretary of U.S. Department of Health and Human Services, contact the: Office of Civil Rights U.S. Department of Health and Human Services 233 N. Michigan Ave., Suite 240 Chicago, IL 60601

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

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

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

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 under certain conditions. You can also 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 events:

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

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

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

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

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

COBRA continuation coverage is a temporary continuation of group health coverage that normally ends 18 months after the event that caused you to lose coverage under the plan. You may pay for COBRA continuation coverage to keep your health coverage. If you lose COBRA coverage, you can purchase individual health coverage at any time, regardless of your health status.
Legal Notices

When is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries in their groups if the plan administrator has not 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 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare benefits on the date he(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. COBRA continuation coverage lasts for up to a total of 36 months. Whenever 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 someone in your group covered under the plan was 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 18 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 in the case of a child, becoming 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 (ERISA) in your area or visit the ERISA web site at www.dol.gov/erica. (Addresses and phone numbers of Regional and District ERISA Offices are available through ERISA'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 of your records, of any notices you send to the plan administrator.

Plan Contact Information:
COBRA Administrator
Ohio Department of Administrative Services
Benefits Administration Services
367 Broad Street, 26th Floor
Columbus, OH 43215
1-800-409.1205, Option 5

Women's Health and Cancer Rights Act

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:

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 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 1.800.490.1205.

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 Cesarean 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 and Affordable Care Act

The Patient Protection and Affordable Care Act, as amended, allows the designation of a primary care provider to 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 Medicare or Medicaid to change primary care providers (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 1.877.445.5977.

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, 2013, to June 30, 2014, with the State of Ohio and about the Medicare Prescription Drug Coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

• Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

• The State of Ohio has determined that the prescription drug coverage offered by Catamaran is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare, or 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, your current State Of Ohio coverage will not be affected. The State of Ohio has determined that the prescription drug coverage offered by Catamaran is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

If you decide to join a Medicare Drug Plan and drop your current state health 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 may pay a higher premium (penalty) if you join a Medicare Prescription Drug Plan or drop your current prescription drug coverage and then join a Medicare 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.

Legal Notices

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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 19 continuous 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 at 1.800.409.1205.

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

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

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

For more information about Medicare prescription drug coverage:

Visit: medicare.gov

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

Call 1-800-MEDICARE (1.800.633.4227)

TTY users should call 1.877.486.2048

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

Remember: Keep this Credible 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, 2013

State of Ohio

Ohio Department of Administrative Services

Benefits Administration Services

Prescription Drug Benefits Manager

50 East Broad, 27th Floor

Columbus, OH 43215

1.800.409.1205

Glossary

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

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

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.

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

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

House Bill 1 (HB 1): Ohio House Bill 1 of the 128th General Assembly created a new category of eligibility for the state medical plan. Medical coverage (including prescription drug and behavioral health benefits) is available to coverage 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.

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

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

SAVE THE DATES

2013

April

• Statewide Walking Challenge begins April 29

May

• Open Enrollment begins May 6

• Healthy Ohio Fitness Walk – May 15

• Open Enrollment ends May 20

June

• Statewide Walking Challenge ends June 10

• Benefit year ends June 30

July

• New Benefit Year begins

October

• Flexible Spending Account Open Enrollment

November

• Great American Smokeout – Nov. 21

December

• Use your remaining Flexible Spending Account money by Dec. 31.

2014

January

• New Flexible Spending Account plan year begins Jan. 1

February

• National Wear Red Day – Feb. 7

March

• 2013 Flexible Spending Account claims deadline – March 31
2013 OPEN ENROLLMENT
MAY 6-20