OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES AND THE JOINT HEALTH CARE COMMITTEE

My Benefits

FOR STATE OF OHIO EMPLOYEES / JULY 1, 2018 – JUNE 30, 2019

INSIDE THE GUIDE

- Open Enrollment information
- Walk-in Clinic vs. Urgent Care vs. Emergency Room
- Cut costs: compare providers
- What you should know before you go to get care

July 1, 2018 - June 30, 2019
Benefits Guide

CONTENTS

Welcome 3
Benefits Provided by the State of Ohio 4
Open Enrollment Periods 6
Benefits Enrollment Instructions 7
Health Benefits 8
Medical Coverage 9
Dependent Eligibility for Benefits 10
Medical Contributions 14
Preventive Care 16
Prescription Drug 18
Behavioral Health 20
Ohio Employee Assistance Program (OEAP) 22
Take Charge! Live Well! 23
Dental 24
Vision 26
Additional Benefits 28
Life Insurance 29
Union Benefits Trust Open Enrollment 32
Disability Benefits 33
Workers' Compensation 34
Flexible Spending Accounts 37
Commuter Choice Program 38
Legal Notices 39
Glossary 49
Health and Other Benefits Contacts 50
Save the Dates 51

Thank You for Your Service

Employment with the State of Ohio is more than just a job – it is a privilege to serve our families, friends and neighbors who rely on us throughout our great state. You are a part of a team of diligent public servants dedicated to delivering excellent, efficient services. You play a key role in our continued success.

The compensation you receive as a State of Ohio employee includes wellness and financial benefits explained in this guide.

The benefits outlined here are effective for the July 1, 2018, to June 30, 2019, benefit year.

John R. Kasich
Governor
State of Ohio

Robert Blair
Director
Ohio Department of Administrative Services

THE JOINT HEALTH CARE COMMITTEE

The labor-management partnership overseeing the State of Ohio employee health care fund

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Co-Chair, Labor;
Ohio Civil Service Employees Association (OCSEA)

KATE NICHOLSON
Co-Chair, Management;
Ohio Department of Administrative Services

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OHIO STATE TROOPERS ASSOCIATION REPRESENTATIVE
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Ohio Department of Rehabilitation and Correction

SEIU 1199 REPRESENTATIVE
BARBARA MONTGOMERY
Ohio Department of Medicaid

Benefits Provided by the State of Ohio

Health Care Benefits		
BENEFIT	**Areas of Coverage**	**Providers/Third-Party Administrators**
Medical Care	*Medical Coverage - Ohio Med PPO* *Prescription Drug* *Behavioral Health* *Wellness Program* *Take Charge! Live Well!*	*Aetna, Anthem, Medical Mutual of Ohio* *OptumRx* *Optum Behavioral Solutions* *Sharecare*
Ohio Employee Assistance Program (OEAP)	*Referral/Informational Services*	*Ohio Employee Assistance Program*
Dental	*Dental Coverage*	*Delta Dental (exempt employees)* *Union Benefits Trust (bargaining unit employees)*
Vision	*Vision Coverage*	*EyeMed Vision Care (exempt employees)* *Union Benefits Trust (bargaining unit employees)*

Additional Benefits		
Benefit	**Areas of Coverage**	**Providers/Third-Party Administrators**
Life Insurance	*Basic Life Insurance*	*Minnesota Life (exempt employees)* *Union Benefits Trust (bargaining unit employees)*
Life Insurance	*Supplemental Life Insurance*	*Minnesota Life (exempt employees)* *Union Benefits Trust (bargaining unit employees)*
Disability	*67 percent* of your base rate of pay while off work for a disabling condition* **Union-represented employees should check your collective bargaining agreement*	*Ohio Department of Administrative Services - Disability Unit*
Workers' Compensation	*Salary Continuation* *Occupational Injury Leave (for specific agencies)* *Temporary Total Compensation*	*Ohio Department of Administrative Services* *Ohio Bureau of Workers' Compensation*
Flexible Spending Accounts (FSA)	*Health Care Spending Account (HCSA)* *Dependent Care Spending Account (DCSA)*	*WageWorks* *WageWorks*
Commuter Choice	*Transit and/or Parking*	*WageWorks*

The State of Ohio provides quality, affordable and competitive benefits to eligible employees. Great care has been taken to select plan providers to ensure you receive quality benefits at competitive rates. Below is a summary of the benefits provided to you. To download the chart, click *here*.

Health Care Benefits

	Eligibility	Effective
	• *Full- and part-time permanent employees* • *Part-time temporary employees who meet the Affordable Care Act eligibility requirements* • *Eligible spouses and dependents younger than 26, or who are 26 and qualify as a disabled dependent*	*First day of the month following a change in status/ qualifying event, such as date of hire or marriage/ divorce. The birth of a child(ren) or adoption/placement of a child is effective the date of the qualifying event.*
	All state employees and their dependents	*Upon employment*
	Full- and part-time permanent employees with one year of continuous state service, and dependents younger than 23, or those who qualify as disabled dependents	*First day of the month following the completion of one year of continuous state service*
	See benefitstrust.org for details	*See benefitstrust.org for details*
	Full- and part-time permanent employees with one year of continuous state service, and dependents younger than 23, or those who qualify as disabled dependents	*First day of the month following the completion of one year of continuous state service*
	See benefitstrust.org for details	*See benefitstrust.org for details*

Additional Benefits

	Eligibility	Effective
	Full- and part-time permanent employees, firefighters, judges and other elected officials serving fixed terms of office with one year of continuous state service.	*First day of the month following the completion of one year of service*
	See benefitstrust.org for details	*See benefitstrust.org for details*
	Full- and part-time permanent employees, firefighters, judges and other elected officials serving fixed terms of office and their eligible dependents.	*For guaranteed issue amounts: first of the following month in which the request for coverage is made. For coverage requiring evidence of insurability (EOI): approval date or first of the following month, whichever is later.*
	See benefitstrust.org for details	*See benefitstrust.org for details*
	Full-time permanent employees who have completed one year of continuous state service *Part-time permanent employees who have completed one year of continuous state service and have worked 1,500 or more hours within the 12 calendar months preceding the date of disability*	*First day of the month following the completion of one year of continuous state service (immediately prior to the date of disability)*
	Full- and part-time permanent employees *All state employees*	*Upon employment* *Upon employment*
	Full- and part-time permanent employees who have completed their initial probationary period at the time of the FSA Open Enrollment *Full- and part-time permanent employees*	*First day of the month following enrollment or Jan. 1*
	All state employees	*First day of the month if you enroll by the fifth of the previous month*

Open Enrollment Periods

OPEN ENROLLMENT IN THE SPRING

MAY 21 THROUGH JUNE 1, 2018

Medical, Dental, Vision and Supplemental Life Insurance

The Open Enrollment period in the spring allows employees the opportunity to enroll or make election changes in the following health care coverage and supplemental life insurance benefits:

- Medical, which includes Behavioral Health, Prescription Drug and Wellness (known as the *Take Charge! Live Well!* program);
- Dental;
- Vision; and
- Supplemental Life Insurance.

This guide informs you and your family about the State of Ohio's employee health care and supplemental life insurance benefits available this coming benefit year, which begins July 1, 2018. Eligible employees can elect to enroll or disenroll themselves and/or their dependents in medical, dental, vision and supplemental life insurance coverage during the Open Enrollment period, which will be held **Monday, May 21 through Friday, June 1**.

If you already are enrolled in benefits:

1. Review your Benefits Summary by logging into *myohio.gov* and clicking the myBenefits button to access benefit information for you as well as your dependents, if applicable.
2. Ensure your dependents still meet the eligibility requirements by visiting *das.ohio.gov/eligibilityrequirements*.

If you do not have any changes to your coverage, no additional action is required.

FLEXIBLE SPENDING ACCOUNTS OPEN ENROLLMENT IN THE FALL

The Open Enrollment period in the fall allows employees the opportunity to enroll in the Flexible Spending Accounts, which include:

- Health Care Spending Accounts; and
- Dependent Care Spending Accounts.

The Flexible Spending Accounts Open Enrollment is administered by WageWorks and is being held in the fall.

See Pages 37 and 38 for more information about these programs.

If you wish to waive your current health care coverage, you will need to do so during Open Enrollment.

Any dependent who is pending documentation approval during Open Enrollment will not be enrolled until required documentation is received by your agency or the Ohio Department of Administrative Services. **Documentation must be submitted by July 31, 2018, for these dependents to be enrolled in coverage.** It is recommended that you submit all required documentation as soon as possible.

Changes for the Upcoming Benefit Year for Exempt Employees

- Vision Plan – Beginning July 1, 2018, the vision plan administrator for exempt employees will change from VSP to EyeMed Vision Care. Exempt employees enrolled in vision coverage will receive a welcome packet from EyeMed in June with two identification cards.

  EyeMed ID cards also can be obtained from the EyeMed website, *eyemed.com*, or the EyeMed mobile app. The EyeMed ID cards are not required when using the benefit.
- Employees enrolled in medical coverage will receive an ID card from Optum Behavioral Solutions in June for use with their behavioral health coverage.
- The third-party administrator for the wellness program (known as *Take Charge! Live Well!*) is now Sharecare, which acquired Healthways in 2016. The program remains the same and is being administered by the same staff and health coaches.

Benefits Enrollment Instructions

MEDICAL, DENTAL AND VISION ENROLLMENT

You can enroll in coverage for medical, dental and/or vision, if eligible, online at *myohio.gov* or via paper enrollment.

If you are a new employee who has not already received your State of Ohio User ID in a letter or email, contact your agency human resources representative. If you have not obtained your password for *myohio.gov*, contact the OAKS Help Desk by calling toll-free, 800-409-1205 (in Columbus, 614-466-8857), option 1, or email *oaks.helpdesk@das.ohio.gov*.

A. ONLINE ENROLLMENT

Login instructions for the original myOhio.gov:

- Go to *myohio.gov*.
- Enter your State of Ohio User ID and password.
- Click on **myBenefits** under Self Service Quick Access on the left side of the page.
- Click on the **Benefits Summary** link.
- Click on **Enroll in Benefits** and make the necessary changes or updates.

Login instructions for the new myOhio.gov:

- Go to *myohio.gov*.
- Enter your State of Ohio User ID and password.
- Click on quick links (four square icon) in the upper right corner of the page.
- Click on **myBenefits** under Self Service Quick Access on the left side of the page.
- Click on the **Benefits Summary** link.
- Click on **Enroll in Benefits** and make the necessary changes or updates.

Benefits System Availability via *myohio.gov*

Non-Payday Week
Monday – Thursday..... Available 24 hours/day
Friday ..... All day until 7 p.m.
(myPay unavailable all day)

Saturday and Sunday..... Unavailable

Payday Week
Monday – Friday ..... Available 24 hours/day
Saturday ..... All day except 4 to 6 p.m.
Sunday..... Unavailable

Deadline – Make and submit your selections through *myohio.gov* by the end of the Open Enrollment period, within 31 days of your hire date or a change in status/qualifying event. Make sure your online elections are correctly submitted. At the end of the process you will receive a confirmation message.

B. PAPER ENROLLMENT

Obtain a paper Benefit Enrollment/Change Form (Form ADM 4717) on the Benefits Administration website at *das.ohio.gov/forms* or from your agency human resources representative.

Deadline – Give your completed and signed Benefit Enrollment/Change Form (Form ADM 4717) to your agency human resources representative within 31 days of your hire date or a change in status/qualifying event.

Bargaining unit employees must complete separate vision and dental forms.

CHANGE IN STATUS/QUALIFYING EVENT DEADLINE

To ensure timely processing of your enrollment, you must complete your enrollment and provide all necessary dependent documentation within 31 days of the change in status/qualifying event. A listing of the required documentation is available at *das.ohio.gov/eligibilityrequirements*. Coverage elections will not be submitted for dependents until all eligibility documents are received and approved by your agency human resources representative.

It can take between two to three weeks from the completion of your enrollment process to receive your medical and prescription drug identification cards.

SUPPLEMENTAL LIFE ENROLLMENT FOR EXEMPT EMPLOYEES

How to Enroll in Supplemental Life

To enroll in supplemental life insurance for exempt employees, visit the Minnesota Life website at *lifebenefits.com*. For login instructions, the initial user ID is "OH" plus your State of Ohio User ID. The initial password is your date of birth (MMDDYYYY) plus the last four digits of your Social Security number. You also may obtain a supplemental life enrollment form on the Forms section of the Benefits Administration website at *das.ohio.gov/forms*.

HEALTH CARE BENEFITS

Medical Coverage 9
- Preventive Care 16
- Prescription Drug 18
- Behavioral Health 20
- Ohio Employee Assistance Program 22
- Wellness 23

Dental 24

Vision 26

Medical:
Aetna
800-949-3104
aetnastateohioemployee.com

Anthem
844-891-8359
enrollment.anthem.com/stateofohio

Medical Mutual of Ohio
800-822-1152
stateofohio.medmutual.com

Prescription Drug
OptumRx
866-854-8850 / *optumrx.com*

Behavioral Health and Substance Use
Optum Behavioral Solutions
800-852-1091 / *liveandworkwell.com*

Ohio Employee Assistance Program
800-221-6327 / *ohio.gov/eap*

Take Charge! Live Well!
Sharecare
866-556-2288 / *ohio.gov/tclw*

Delta Dental of Ohio (exempt employees)
800-524-0149
deltadentaloh.com

EyeMed Vision Care (exempt employees)
888-838-4033 / *eyemed.com*

Union Benefits Trust
614-508-2255 / 800-228-5088
benefitstrust.org

Benefits Provided by the State of Ohio

Your health benefits include medical, prescription drug, behavioral health, dental, vision and the *Take Charge! Live Well!* program. The benefit year is the 12-month period from July 1 through June 30 during which services are rendered and your deductible and coinsurance are accumulated.

All of the State of Ohio health plans are self-funded programs. This means that the cost of benefits is funded by contributions from you and the State of Ohio. All claims for services and procedures are paid directly from these contributions. When the amount of claim payments is greater than the amount of contributions from employees and the state, medical costs increase.

Employee Contributions + State Contributions = TOTAL CONTRIBUTIONS

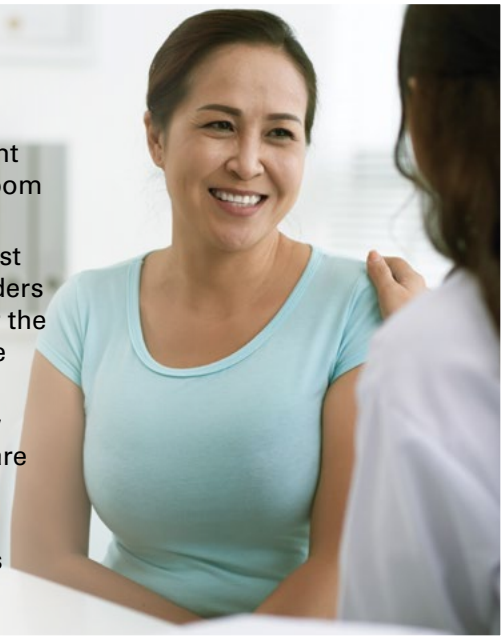
Being smart consumers and making informed choices is one way to keep the cost of medical claims down. State employees can help by choosing a primary care physician and visiting him or her regularly. Developing a relationship with a primary care physician can reduce trips to the emergency room and other urgent care facilities.

Also, the State of Ohio's third-party administrators offer helpful tools on their websites to assist you in making smart decisions. These tools can help you identify an in-network primary care physician that best fits your needs. Because the costs for the same services can vary widely (e.g., X-ray, colonoscopy, MRI, etc.), using these tools can result in savings for you and the state. For more information, see the third-party administrator contact information on this page.

Another way to keep claim costs low is by taking care of yourself and your family's health. The State of Ohio offers many preventive care benefits, often at no cost to you or your dependents. See the chart of available services on Page 16. The state also offers its employees and spouses a wellness program, known as *Take Charge! Live Well!,* to aid you in your quest to be mentally, physically and fiscally healthy.

Take advantage of your benefits with the following information:

- Walk-in Clinic vs. Urgent Care vs. Emergency Room (Page 13);
- Compare providers. Just like retail stores, providers have different costs for the same procedures (Page 13);
- What you should know before you go to get care (Page 17); and
- Mobile apps for your benefits administrators (Page 17).



Medical Coverage

As an eligible employee enrolling in medical coverage, you automatically gain prescription drug, behavioral health and *Take Charge! Live Well!* benefits.

COST

Each employee who is enrolled in the Ohio Med Preferred Provider Organization (PPO) Plan, the State of Ohio's medical plan, pays a portion of the total contribution through pre-tax biweekly or monthly payroll contributions for their coverage. The remaining portion of the total contribution is paid for by the State of Ohio. See the chart on Page 14. Your out-of-pocket costs will be assessed as outlined on Page 15.

ELIGIBILITY

Most state employees are eligible for medical coverage effective the first day of the month following their date of hire or if they experience a change in status/qualifying event. Dependents are eligible for medical coverage up to the age of 26. See Pages 10 and 11 for more details. Coverage may be continued after age 26 if the dependent qualifies as disabled or elects coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Full-time and Part-time Permanent Employees Only

You are eligible for the state's medical benefits if you are a full-time or part-time permanent employee.

Part-time Permanent Employees Only

- The contribution tier for part-time permanent employees is determined annually.
- The percentage that part-time permanent employees pay toward their contributions is based on their average number of service hours. Average service hours are calculated over a 12-month period (called the Standard Measurement Period), which begins the first pay period in May and goes through the last pay period in April. Any change in your contribution becomes effective July 1, the beginning of the new plan year.

Average service hours per week	Percent of Contribution you pay
0-19.99 hours	100%
20-29.99 hours	50%
30+ hours	15%

Part-time Temporary Employees Only

The Affordable Care Act requires the State of Ohio to offer only medical coverage to all part-time temporary employees who average at least 30 service hours per week over a 12-month measurement period (called the Initial Measurement Period).

- Part-time temporary employees are those typically hired as interns, intermittents or external interim employees. This does not include AmeriCorps volunteers or contingent workers.
- Part-time temporary employees who are hired with a reasonable expectation of averaging 30 or more service hours per week in their first 12 months of employment will be eligible to enroll in medical coverage at the date of hire. Coverage is effective the first day of the month following the date of hire. The State of Ohio cannot terminate the coverage until 12 months has expired, you terminate service with the State of Ohio for more than 31 days or you experience a change in status/qualifying event.
- Part-time temporary employees who are hired with a reasonable expectation of averaging 29.99 service hours or less per week will not be eligible to enroll in medical coverage at the time of hire. Instead, you will be measured over the 12-month Initial Measurement Period.
- The Initial Measurement Period begins the first full pay period after the first pay period with one or more service hours credited.
- Upon completion of the Initial Measurement Period, if you average 30 or more service hours, you will be offered the opportunity to enroll in medical coverage the first of the month following the end of the Initial Measurement Period.

Dependent Eligibility for Benefits

Dependent Category	Medical	Dental	Vision	Supplemental Life
Children younger than age 23	Coverage available for eligible dependents[1]	Coverage available for eligible dependents[2]	Coverage available for eligible dependents[2]	Coverage available for eligible dependents
Children ages 23 - 25	Coverage available for eligible dependents[1]	No coverage available	No coverage available	Coverage available for eligible dependents

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

[2] Student verification is needed for dependents age 19 to age 23. View 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 (e.g., divorce, change in student status), it is your responsibility to contact your agency human resources representative immediately to remove him or her from your coverage. If removed, your dependent may be eligible to continue his or her medical, dental and/or vision benefits through COBRA if you notify your agency human resources representative within 60 days after the change in status/qualifying event.

Enrollment or continuation of enrollment of an ineligible dependent may result in loss of benefits, disciplinary action and/or repayment of claims. If you fail to remove a dependent from coverage within 31 days of a change in status/qualifying event, you may be responsible for health care expenses incurred by the ineligible dependent.

DEPENDENT ELIGIBILITY

Family members described below may be eligible for coverage under your health benefits package.

Note: Dependent children are only eligible for dental and vision benefits if unmarried and younger than age 23; however, dependent children ages 19 through 22 must be students.

Documentation will be required at the time of dependent enrollment to verify eligibility.
To view the detailed eligibility and documentation requirements for all dependents, please go to *das.ohio.gov/eligibilityrequirements*.

1. **Spouse**
   - Your current legal spouse as recognized by Ohio law.
2. **Children younger than age 26 including:**
   - Your biological children (married or unmarried);
   - Your legally adopted children: adopted children have the same coverage as children born to you or your spouse, whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption;
   - Your stepchildren;
   - Non-emancipated foster children. Emancipation is defined as the age of 18 unless specifically stated in the court order;
   - Non-emancipated children for whom either you or your spouse has been appointed legal guardian; and
   - Children for whom the plan has received a Qualified Medical Child Support order: the child must be named as your alternate recipient in the order.
3. **Unmarried children incapable of self-care**
   Unmarried children who are incapable of self-support due to a qualifying developmental disability, severe mental illness or physical handicap, whose disability began before age 23 and who are primarily dependent upon you are eligible for medical coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled for coverage, provided that the application is submitted within five years following loss of coverage.

   This coverage is not automatic. You must complete the applicable form for your third-party administrator of the Ohio Med PPO. A form for each third-party administrator can be obtained from your agency's human resources representative.

   Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

Examples of persons not eligible for coverage as a dependent include, but are not limited to:

- A spouse from whom the employee is legally divorced or legally separated;
- Live-in boyfriend or girlfriend;
- Parents or parents-in-law;
- Grandchildren (unless the employee is the court-appointed legal guardian);
- Adults who are not the employee's or spouse's children under guardianship of employee (brother, sister, aunt, uncle, etc.);
- A spouse from a common-law marriage established after Oct. 10, 1991;
- Any other members of your household who do not meet the definition of an eligible dependent;
- A child who is eligible as an employee of the State of Ohio is not eligible as the dependent of a parent who also is a State of Ohio employee, except as required by the Patient Protection and Affordable Care Act; and
- A child of a state employee cannot also be covered as the spouse of another state employee.

Employees are required to disenroll a dependent who becomes ineligible.

Providing false or misleading dependent eligibility information may result in any or all of the following actions by the State of Ohio:

- Loss of coverage;
- Disciplinary action, up to and including dismissal;
- Collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible; and/or
- Civil and/or criminal prosecution.

Visit the Definitions and Required Documents Checklist at *das.ohio.gov/eligibilityrequirements* to learn what is needed to disenroll an ineligible dependent.

3-DIGIT ZIP CODE BREAKDOWN

The state contracts with Aetna, Anthem and Medical Mutual of Ohio to serve as the third-party administrators for the Ohio Med PPO Plan. This plan allows employees and eligible dependents to have access to both network and non-network providers.

Aetna, Anthem and Medical Mutual of Ohio each serve State of Ohio employees based on the first three digits of their home ZIP code. Please review the ZIP code chart below to find your plan administrator. Employees with home ZIP codes outside Ohio will be enrolled in Anthem.

Aetna **Plan/Network: Aetna Choice POS II (Open Access)**	**3-Digit ZIP Code**			
	Columbus, Toledo			
	430	431	432	433
	434	435	436	448
	449			

Anthem **Plan/Network: Blue Access (PPO)**	**3-Digit ZIP Code**			
	Cincinnati, Dayton Southern Ohio, Springfield Youngstown, Out of State			
	437	438	439	444
	445	450	451	452
	453	454	455	456
	457	458		

Medical Mutual of Ohio **Plan/Network: OhioMed**	**3-Digit ZIP Code**			
	Akron, Cleveland			
	440	441	442	443
	446	447		

SPECIFIC BENEFIT INFORMATION

The Ohio Med PPO plan does not contain pre-existing condition exclusions; therefore, coverage is available to you and your eligible dependents regardless of current health or health history.

Your out-of-pocket costs, such as copayments, deductibles and co-insurance, are shared and combined with your behavioral health plan. If you receive services prior to meeting your 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.

For specific plan information, see Pages 14 and 15.

ENROLLMENT

You can enroll online using *myohio.gov*. See the Benefits Enrollment Instructions on Page 7.

If you do not enroll within 31 days of your date of hire or after you experience a change in status/qualifying event, you must wait until the next annual Open Enrollment period (typically held in the spring).

If you do experience a future change in status/qualifying event, you will have 31 days to add or remove yourself or your dependent(s) to or from coverage.

Visit the Definitions and Required Documents Checklist at *das.ohio.gov/eligibilityrequirements* to learn what is needed to enroll an eligible dependent.

Summary of Benefits and Coverage

A requirement of the Affordable Care Act, the Summary of Benefits and Coverage (SBC), is a comprehensive document that details simple and consistent information about medical 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, out-of-pocket 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. To learn more, visit *das.ohio.gov/benefits*. The SBC is listed along the right navigation pane under the Publications and Notices section.

Finding the Right Care

Find the Right Care for You		
Options	What it is	Best for
Walk-in Clinic $	Clinic in retail store or pharmacy staffed by nurse practitioners	Basics: Ear/sinus infections, sore throat/ strep, minor sprains, bronchitis, coughs, cold/flu, vaccines
Urgent Care Center $$	Self-standing center or located in health facility; staffed by physicians and nurses	Serious, not life-threatening: Fractures or sprains needing X-rays, deep cuts needing stitches, severe rash
Emergency Room $$$	Hospital department open 24/7; staffed and equipped for life-threatening care	Threat to life or limb: Chest pain, difficulty breathing, seizures, major break, head trauma, bleeding, allergic reaction, loss of consciousness

Where to Get Care

RIGHT CARE. RIGHT PLACE. RIGHT TIME.

Non-Emergency

- 24-hour Nurse Advice Line 866-556-2288, option 1
- Home/local
  - Call your primary doctor.
  - He/she knows you and your health best.
- After-hours or traveling
  - Call your doctor for advice, if possible.
  - Ask questions and understand your options if he/she isn't able to see you.

Need Surgery? Choose Wisely.

COMPARE HOSPITALS

- Leapfrog Group Hospital Safety Score
  - Gold standard: Measures quality, safety, performance and transparency
  - Review results online at no cost.
  - *hospitalsafetygrade.org*
- Hospital Compare
  - Summarizes up to 64 quality measures.
  - *medicare.gov/hospitalcompare*

Source: Health Action Council

Save Money: Use Benefits Wisely

All of the State of Ohio's health plans are self-funded. This means that the cost of your benefits is funded by contributions from you and the State of Ohio. All claims are paid from these contributions. Your third-party administrator does not pay for them. Rather, Aetna, Anthem and Medical Mutual of Ohio are paid an administrative fee to review claims and process payments. When the amount of claim payments is greater than the amount of contributions from you and the State of Ohio, medical costs increase.

It is up to each of us to use our benefits wisely. We can all do our part by making wellness a priority in our lives, evaluating our options when we need care and avoiding unnecessary visits.

Take advantage of consumer tools provided by our medical third-party administrators that enable you to shop and find lower costs for the services provided (MRIs, labs, surgeries, etc.) by visiting your third-party administrator's website listed on Page 8.

Full-Time Employee Medical Contributions

	Full-Time Permanent Part-Time Permanent (30 or more hours a week) Part-Time Temporary (30 or more hours a week) Biweekly Paid Employee Contributions[1] 15% tier			Full-Time employees Monthly Paid Employee Contributions[1] 15% tier		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$49.40	$278.88	$328.28	$107.04	$604.25	$711.29
Family Minus Spouse	$135.27	$765.47	$900.74	$293.09	$1,658.48	$1,951.57
Family Plus Spouse[2]	$141.04	$765.47	$906.51	$305.59	$1,658.48	$1,964.07

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

Part-Time Employee Medical Contributions

	Part-Time Permanent (20.00 - 29.99 hours a week) Biweekly Paid Employee Contributions[1] 50% Tier			Part-Time Permanent Employees (up to 19.99 hours a week) Biweekly Paid Employee Contributions[1] 100% Tier		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$164.14	$164.14	$328.28	$328.28	$0.00	$328.28
Family Minus Spouse	$450.37	$450.37	$900.74	$900.74	$0.00	$900.74
Family Plus Spouse[2]	$456.14	$450.37	$906.51	$906.51	$0.00	$906.51

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

Ohio Med PPO

	Out-of-Pocket Costs
Annual Deductible	$250 single, $500 family in-network; $500 single, $1,000 family out-of-network. This deductible is combined with behavioral health
Your Copayments (Office Visits)	Primary care physician: $20 in-network, $30 out-of-network; Specialist: $25 in-network: $30 out-of-network
Coinsurance	You pay 20%, plan pays 80% in-network; you pay 40%, plan pays 60%[1] out-of-network
Your Out-of-Pocket Maximum [2]	$1,500 single, $3,000 family in-network; $3,000 single, $6,000 family[3] out-of-network. This deductible is combined with behavioral health.
Benefit/Service	**Coverage Levels**
Chiropractic Care	▪ Covered at 80% in-network; 60% out-of-network ▪ Unlimited visits (review required after 25 visits)
Diagnostic, X-Ray and Lab Services	▪ Covered at 80% in-network; 60% out-of-network
Durable Medical Equipment	▪ Covered at 80% in-network; 60% out-of-network
Emergency Room	▪ Covered at 80%; $100 copay, which is waived if patient is admitted as inpatient; 60% out-of-network for non-emergency
Hearing Loss[4] (Accidental, Injury or Illness)	▪ Covered at 80% in-network; 60% out-of-network ▪ Hearing aids, exams and follow-ups are included in coverage
Home Health Care	▪ Covered at 80% in-network; 60% out-of-network; limit of 180 days
Hospice Services	▪ Covered at 100% with no copay, time or dollar limitations for both in- and out-of-network
Immunizations	▪ Most are covered at 100% in-network; 60% out-of-network[5]
Infertility Testing	▪ Covered at 80% after applicable copay, for in-network; 60% after $30 copay out-of-network ▪ Coverage includes testing only
Inpatient and Outpatient Services	▪ Covered at 80% in-network; 60% out-of-network
Maternity - Delivery	▪ Covered at 80% in-network; 60% out-of-network
Maternity-Prenatal/ Postpartum Care	▪ Prenatal Care: Office visits covered at 100% when billed separately from delivery; tests/procedures covered at 80% in-network; 60% out-of-network. Postpartum Care: breast-feeding support and counseling (including lactation classes), and supplies (including breast pump rental) covered at 100%
Physical, Occupational and Speech Therapy	▪ Covered at 80% in-network; 60% out-of-network ▪ Unlimited visits (review required after 25 visits) ▪ Includes coverage for Autism Spectrum Disorder
Preventive Exams and Screenings[6]	▪ Most preventive care covered at 100% in-network; 60% out-of-network ▪ Age restrictions may apply
Skilled Nursing Facility	▪ Covered at 80%; 180-day limit, additional days covered at 60% for both in- and out-of-network
Urgent Care	▪ $30 copay in-network; $35 copay out-of-network ▪ Covered at 80% in-network; 60% out-of-network

[1] Plan pays 60% of Ohio Med PPO Plan's contracted allowable amount and you pay any remaining balance, known as balance billing.
[2] For prescription drug out-of-pocket cost information, see chart on Page 19.
[3] If your out-of-network charge is greater than the Ohio Med PPO Plan contracted allowable amount, your out-of-pocket costs will be more.
[4] Hearing aids for natural hearing loss are covered at 50%, up to $1,000 per lifetime.
[5] For a list of immunizations paid at 100%, see Page 16.
[6] See Preventive Care chart on Page 16.

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 healthy actions you can take is to schedule regular check-ups and screenings with your primary care physician.

Your State of Ohio PPO Plan 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
Stool for occult blood	1/plan year
Urinalysis	1/plan year
Well-baby, well-child exam	Various for birth to 2 years; then annual to age 21
Well-person exam (annual physical)	1/plan year

Free Immunizations	
Diphtheria, tetanus, pertussis (DTap)	2/4/6/15-18 months; 4-6 years
Haemophilus influenza b (Hib)	2/4/6/12-15 months
Hepatitis A (HepA)	2 doses between 1-2 years
Hepatitis B (HepB)	Birth; 1-2 months; 6-18 months
Human Papillomavirus (HPV)	3 doses for 9-26 years
Influenza	1/plan year
Measles, mumps, rubella (MMR)	12-15 months, then at 4-6 years; adults who lack immunity
Meningococcal (MCV4)	1 dose between 11-12 years or start of high school or college
Pneumococcal	2/4/6 months; 12-15 months; annually at age 65 and older; high risk groups
Poliovirus (IPEV)	2 and 4 months; 6-18 months; 4-6 years
Rotavirus (Rota)	2/4/6 months
Tetanus, diphtheria, pertussis (Td/Tdap)	11-12 years; Td booster every 10 years, 18 and older
Varicella (Chickenpox)	12-15 months; 4-6 years; 2 doses for susceptible adults
Zoster (shingles)	1 dose for age 19 and older

The best care starts with you:
Things to know before you go

BE A BETTER PATIENT
Before you go:

- Grab a notepad and pen.
- List and describe symptoms:
  - What? I get a sharp/dull/throbbing pain...
  - Where? In my stomach/knee/neck...
  - When? When I cough/walk...
  - How often? Once in a while/constant...
- List any prescription or over-the-counter drugs, vitamins and supplements you take.
- Ask a friend or family member to go with you.

GET ALL THE FACTS
Know what to ask

1. How will this treatment help me?
2. Are there simpler alternatives?
3. What is this test for?
4. When will I get the results?
5. How many times have you done this procedure?
6. What are the possible complications?
7. What does this drug do? Any side effects?
8. Is this drug offered as a generic or over-the-counter?
9. Will this interact with other medications/supplements I take?

WORK WITH YOUR DOCTOR
Ask • Listen • Learn

- Ask your doctor:
  - "What's causing this?"
  - "What's next?"
    - Medication?
    - Referrals/tests?
    - Cost?
    - Self-care at home/rehab?
  - "What will this do for me?"
- Listen and take notes.
- Learn by following up.

HELP IS AT YOUR FINGERTIPS
Remember to check your insurance carrier's website for no-cost tools available to help you in your decision-making process.

Source: Health Action Council

Stay connected 24/7 with these apps

Download the following apps from the Apple Store or Google Play:

- Aetna
- Anthem
- Medical Mutual of Ohio
- OptumRx (Prescription Drug)
- Optum: myLiveandworkwell (Behavioral Health)
- Delta Dental
- EyeMed Vision Care
- WageWorks

Prescription Drug

OptumRx provides prescription drug benefits for State of Ohio employees and their dependents who are enrolled in the Ohio Med PPO Plan.

COST

Access to the prescription drug benefits are included in the total contributions of your medical coverage. Your copayments will be assessed as outlined on Page 19.

ELIGIBILITY

Employees and dependents enrolled in the Ohio Med PPO Plan automatically receive prescription drug benefits.

SPECIFIC BENEFIT INFORMATION

Diabetes Management Program

Members are eligible for free diabetic supplies and medication if they have had a hemoglobin A1C test within the past 12 months of being a member of the Ohio Med PPO Plan.

Specialty Drug Management Program

Some specialized medications for serious medical conditions such as cancer, cystic fibrosis and rheumatoid arthritis must be obtained from Briova, the specialty pharmacy, and can only be filled for 30 days or less. Your order may be shipped to your home or workplace, if permitted. A description of the program and a list of specialty medications are available on the Benefits Administration website at *das.ohio.gov/prescriptiondrug* under the Specialty Drug List.

Not All Drugs are Covered

Some drugs require the use of alternative medications before being approved.

This is known as "step therapy." Examples include medications used for heartburn, glaucoma, multiple sclerosis, diabetes, asthma, elevated triglycerides, migraines, osteoporosis, nasal allergies, sleep disturbances and high blood pressure. Additional medications requiring step therapy may be added at any time. If this occurs, members currently using the affected drugs will be notified in advance by mail.

A program description and a list of medications are located on the Benefits Administration website, *das.ohio.gov/prescriptiondrug*, under "Prescription Drug Updates."

Prescription Drug Website Offers Online Tracking, Tools

The website for OptumRx, *optumrx.com*, is a private, secure website. All of your pharmacy plan information is available at your fingertips 24/7.

You will need your pharmacy member ID number located on your OptumRx card to log in. The number begins with the letter "A." For questions, contact OptumRx at 866-854-8850.

Easy access to the OptumRx website allows you to:

- Compare mail-order prices and prices at local pharmacies;
- Find your lowest copay;
- Locate a pharmacy and get driving directions;
- Manage your mail-order prescriptions, including options to request a refill or track an order; and
- Learn more about your prescription drugs.

ENROLLMENT

You automatically gain coverage in prescription drug benefits when you are enrolled in medical coverage.

Prescription Copayment Costs

TYPE OF MEDICATION	30-Day Supply at Retail Copayment	30-Day Supply Specialty Copayment	90-Day Supply at Retail Copayment	90-Day Supply at Mail-Order Copayment
Generic	$10	$10	$30	$25
Preferred Brand-Name	$30	$30	$90	$75
Non-Preferred Brand-Name, Generic Unavailable	$55	$55	$165	$137.50
Non-Preferred Brand-Name, Generic Available	$55 plus the difference between the cost of the brand-name and generic drug	$55 plus the difference between the cost of the brand-name and generic drug	$165 plus the difference between the cost of the brand-name and generic drug	$137.50 plus the difference between the cost of the brand-name and generic drug
Out-of-Pocket Maximum*	$2,500 single/$5,000 family These amounts are for copays only and do not include cost differential amounts.			

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.

The maximum copay for oral oncology medications will be $100 for a 30-day supply. For more details, visit *das.ohio.gov/prescriptiondrug*.

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

Behavioral Health

Specialized behavioral health and substance use services are provided under a single program available to all employees and dependents enrolled in the Ohio Med PPO Plan.

COST

Access to the behavioral health benefits are included in the total contributions of your medical coverage. Your out-of-pocket costs will be assessed as outlined in the chart below.

ELIGIBILITY

Employees and dependents enrolled in the Ohio Med PPO Plan automatically receive Behavioral Health benefits.

SPECIFIC BENEFIT INFORMATION

This program, administered by Optum Behavioral Solutions, provides 24-hours-a-day, seven-days-a-week, confidential phone assessment and referral services for a variety of behavioral and mental health issues, such as:

- Substance use disorders;
- Depression;
- Autism Spectrum Disorder;
- Marital, family and relational issues;
- Grief and loss;
- Stress;
- Serious mental illness;
- Anger management;
- Mental disorders; and
- Physical abuse.

The following Autism Spectrum Disorder services are available to members with a related medical diagnosis:

1. Behavioral and mental health outpatient services performed by a psychologist, psychiatrist, physician or board-certified behavior analyst who is a licensed, qualified and approved provider for consultation/assessment, development or oversight of treatment plans.
   A. Applied behavioral analysis (ABA) services are limited to 20 hours per week, including services provided for a consultation or assessment, or development or oversight of ABA treatment plans.
   B. Applied behavioral analysis services must be pre-certified. Treatment that is not pre-certified may result in no coverage.
   C. An hour is defined as each hour billed by the provider. For example, if two specialists are providing service for one hour, it would be calculated as two hours.
2. Clinical Therapeutic Intervention administered by or under the supervision of a qualified/approved provider, in accordance with an approved applied behavioral analysis treatment plan, limited to 20 hours per week.

Your out-of-pocket costs, such as copayments, deductibles and co-insurance, are shared and combined with your medical plan. If you receive services prior to meeting your deductible, you may

Ohio Med PPO

	Out-of-Pocket Costs
Annual Deductible	$250 single, $500 family in-network; $500 single, $1,000 family out-of-network. This deductible is combined with medical.
Your Copayments	$20 outpatient office visit in-network, $30 outpatient office visit out-of-network (balance billing applies); $20 intensive outpatient care in-network, $30 intensive outpatient care out-of-network (balance billing applies).
Coinsurance	• Outpatient in-network: 100% after office visit copay, 80% of other services; • Outpatient out-of-network: 60% of fee schedule after copayment (balance billing applies); • Inpatient in-network: 80% after deductible; • Inpatient out-of-network: 60% after deductible, $350 penalty if not preauthorized.
Your Out-of-Pocket Maximum	$1,500 single in-network, $3,000 family in-network; $3,000 single out-of-network, $6,000 family out-of-network. This deductible is combined with medical.
Other	No day, annual or lifetime limits. Some benefit limits may apply: For details, visit *das.ohio.gov/behavioralhealth*, click the Summary Plan Descriptions tab and select the current summary plan.

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.

All enrolled employees and their dependents have access to both in-network and out-of-network behavioral health benefits. However, you will pay more if you do not use the network of participating providers and facilities. See the Ohio Med PPO chart on Page 20 for coverage information.

Support for dependents battling substance use
The state's health plan offers Optum's Family Support Program to help care for a dependent up to age 26 who has a substance use problem. The Family Support Program gives you confidential phone access to licensed mental health clinicians with in-depth knowledge of alcohol or drug addictions and treatment. The program is available at no additional cost.

When you call the program, a family support specialist will do a thorough assessment of your situation. The support specialist will:

- **Educate** you about addiction and community resources for you and your loved one;
- **Guide** you through treatment options and refer you to the appropriate treatment centers or clinicians; and
- **Support** you in communicating with your child and taking care of yourself and other family members by providing connections to support services.

For details about Optum's Family Support Program, call either the Ohio Employee Assistance Program, 800-221-6327, or the Family Support Program's toll-free phone number, 877-229-3440 (TDD/TYY: Dial 711 and the phone number), or log onto Optum's Live and Work Well website, *liveandworkwell.com*, and enter the access code: 00832.

ENROLLMENT

You automatically gain coverage in behavioral health benefits when you are enrolled in medical coverage.

Ohio Employee Assistance Program

COST
As a State of Ohio employee, there is no cost to you for the Ohio Employee Assistance Program (OEAP). Each state agency pays a percentage of its payroll into this benefit.

ELIGIBILITY
All State of Ohio employees and their dependents are eligible to utilize OEAP services. You do not need to be enrolled in the Ohio Med PPO for these services.

SPECIFIC BENEFIT INFORMATION
The State of Ohio offers confidential support services through the OEAP for various behavioral health issues, which include mental health and substance use referrals for employees and their dependents. Other OEAP services include training and education, critical incident stress management, employee mediation, organizational transition intervention and the OEAP participation agreement for those experiencing workplace discipline due to work rule violations.

Visit *ohio.gov/eap* for more information about OEAP services.

ENROLLMENT
Employees and their dependents may use the OEAP's services at any time during their employment with the State of Ohio. There is no need to enroll.

Caregiver Resources

Are you a caregiver for an adult loved one?

To learn about the resources available to you, visit: *das.ohio.gov/caregiver*.

Get information about:

- Care for:
  - An aging adult;
  - An adult in need of assisted living or a nursing home;
  - A low income adult who needs health care coverage;
  - An adult with a disability;
  - An adult with a developmental disability;
  - A veteran; and
- Legal resources.

For support contact the Ohio Employee Assistance Program by email, *oeap@das.ohio.gov*, or by phone, 1-800-221-6327.

Take Charge! Live Well!

As we grow increasingly busy, leading a healthy lifestyle can be more challenging. We have to work harder to manage what we eat, how often we exercise and how we manage stress.

In your effort to become a healthier you, *Take Charge! Live Well!* – the health and wellness program for state employees and spouses enrolled in the Ohio Med PPO Plan – is there for you with programs and other resources such as financial well-being, monthly well-being challenges and articles about health and wellness topics as well as rewards offered to encourage you in your efforts.

COST

Access to the wellness benefits are included in the cost of your medical coverage.

ELIGIBILITY

Employees and spouses enrolled in the Ohio Med PPO Plan automatically receive *Take Charge! Live Well!* benefits.

SPECIFIC BENEFIT INFORMATION

A healthier you starts with completing the following:

- Your **Gallup-Sharecare Well-Being 5™ survey and Well-Being Plan**, via Well-Being Connect, the website of Sharecare, the State of Ohio's wellness administrator; and
- A **biometric screening**, either at your workplace or through your physician.

How to obtain your rewards:

1. Assess your well-being and earn up to $150.
   - Earn $100 for completing a biometric screening; and
   - Earn $50 for completing the Gallup-Sharecare Well-Being 5 survey.
2. Participate in well-being improvement activities and earn up to $200 more. Mix and match the programs as you choose to get the rewards the way you prefer, up to four activities.
   - Earn $50 for each coaching call;
   - Earn $50 for each well-being challenge when you meet the active participation requirement; or
   - Earn $50 for each online lesson you complete for the Sharecare Financial Well-Being™ program, powered by Dave Ramsey.

Choose Your Own Reward

After completing an activity that merits a reward, you may choose a PNC VISA reward card or a reward card from other national brands.

You can request to receive your reward card after completing a single activity, like your biometric screening or Well-Being 5 survey, or you can allow your rewards to accumulate for a larger payout after completing multiple activities. This puts you in control of when you receive your reward card.

ENROLLMENT

You automatically gain access to the health and wellness program when you are enrolled in medical coverage.

Wellness Rewards

Enrolled employees and spouses may earn up to $350 each by taking steps to improve their health

Level 1: Assess Your Health	Point Value
Earn up to $150 per person in Level 1	
Complete your Well-Being 5 survey.	50 Points
Biometric screening: • Complete an on-site screening; or • Submit the Physician Form, which is to be completed by your physician.	100 Points
Level 2: Take Action	**Point Value**
Earn up to $200 in Level 2 Points can be earned by completing up to four total actions within the same activity or by combining actions with multiple activities.	
Coaching Calls	Earn 50 points for each completed coaching call, up to four calls
Well-Being Challenges	Earn 50 points for each completed challenge, up to four challenges
Financial Well-Being	Earn 50 points for each completed Financial Well-Being lesson, up to four lessons
Reward cards are taxable compensation. Taxes are based on the amount of your reward and will be deducted from your paycheck. For details about rewards and the *Take Charge! Live Well!* program, go to the *Take Charge! Live Well!* program website, *ohio.gov/tclw*, and click on the **Program Guide** button.	

Dental (FOR EXEMPT EMPLOYEES)

Dental coverage is offered to exempt employees through Delta Dental of Ohio.

COST

The state pays the total contributions for exempt full-time and part-time permanent employees and their eligible dependents. See the chart below.

Monthly Contributions for Dental Coverage			
	Employee Share	State Share	Total
Single	$0	$34.23	$34.23
Family	$0	$99.19	$99.19

ELIGIBILITY

Employee Eligibility

Exempt full-time and part-time permanent employees are eligible to enroll in dental coverage effective the first day of the month following the completion of one year of continuous state service or thereafter during Open Enrollment.

Dependent Eligibility

1. **Spouse**
   Your current legal spouse as recognized by Ohio law.
2. **Children younger than age 19 including:**
   - Your unmarried biological children;
   - Your legally adopted children. Adopted children have the same coverage as children born to you or your spouse, whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption;
   - Your stepchildren;
   - Non-emancipated foster children. Emancipation is defined as the age of 18 unless specifically stated in the court order;
   - Non-emancipated children for whom either you or your spouse has been appointed legal guardian; and
   - Children for whom the plan has received a Qualified Medical Child Support order. The child must be named as your alternate recipient in the order.
3. **Children between the ages of 19 and 23 with approved student status**
   Dependents between the ages of 19 and 23 are eligible for continued coverage as long as they maintain their student status. Student coverage is not automatic. To initiate or continue coverage for your dependent, you are required to submit proof of eligibility within 31 days of the change in status/qualifying event.

   Student status required documents:

   - An "Affidavit of Student Status" form, accessed at *das.ohio.gov/forms* in the "Eligibility" section; and
   - A "Current Enrollment Verification Certificate" from the National Student Clearinghouse, *studentclearinghouse.org*, or a letter or official transcript from the school registrar must be submitted with the Affidavit of Student Status.

   If the proof of eligibility is provided timely, the dependent will remain on your dental coverage until he or she turns 23 or experiences a change in status/qualifying event, such as graduating from college or getting married.
4. **Unmarried children incapable of self-care**
   Unmarried children who are incapable of self-support due to a qualifying developmental disability, severe mental illness or physical handicap, whose disability began before age 23 and who are primarily dependent upon you are eligible for medical coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled for coverage, provided that the application is submitted within five years following loss of coverage.

   This coverage is not automatic. You must complete the applicable form for your third-party administrator of the Ohio Med PPO. A form for each third-party administrator can be obtained from your agency's human resources representative.

   Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

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

SPECIFIC BENEFIT INFORMATION

For plan specifics and deductible information, see the Delta Dental Plan for Exempt Employees chart below.

You can receive services from any licensed dentist, but typically will pay less when you go to an in-network dentist.

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 will pay a higher percentage if you go to a dentist in its preferred provider organization (PPO) network over its Premier network. Delta pays the least for out-of-network dentists.

To find a participating Delta Dental dentist near you, visit or call:

deltadentaloh.com
800-524-0149
Group Number: 9273-0001

If you would like a Delta Dental ID card to present to your dentist, you may print a card from the Delta Dental website, *deltadentaloh.com*. ID cards are not required when using the dental benefit.

ENROLLMENT

An enrollment packet will be mailed to you prior to your one-year anniversary. Coverage will be effective the first day of the month following the completion of one year of continuous state service, as long as you have submitted your enrollment within 31 days of your anniversary date. See the Benefits Enrollment Instructions on Page 7.

Delta Dental Plan for Exempt Employees

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist**
Benefit Year* Maximum	$1,500	$1,500	$1,500
Diagnostic and Preventive Services	100%	100%	100%
Basic Restorative Services (e.g., fillings)	100%	65%	65%
Major Restorative Services (e.g., crowns, bridges)	60%	50%	50%
Orthodontia	50% up to $1,500 lifetime maximum	50% up to $1,500 lifetime maximum	50% up to $1,500 lifetime maximum

Prophylaxes (cleanings) are payable twice per benefit year. Two additional periodontal maintenance procedures are payable per benefit year for individuals with a documented history of periodontal disease.

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

There is a separate $1,000 per person total per lifetime maximum on implants and surgical stents.

* The benefit year is from July 1 through June 30 of each year.

** 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 nonparticipating 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.

Vision (FOR EXEMPT EMPLOYEES)

Vision coverage is offered to exempt employees through EyeMed Vision Care.

COST

The state pays the total contributions for exempt full-time and part-time permanent employees and their eligible dependents. See the chart below.

Monthly Contributions for Vision Coverage			
	Employee Share	State Share	Total
Single	$0	$10.04	$10.04
Family	$0	$27.61	$27.61

ELIGIBILITY

Employee Eligibility

Exempt full-time and part-time permanent employees are eligible to enroll in vision coverage effective the first day of the month following the completion of one year of continuous state service or thereafter during Open Enrollment.

Dependent Eligibility

1. **Spouse**
   - Your current legal spouse as recognized by Ohio law.
2. **Children younger than age 19 including:**
   - Your unmarried biological children;
   - Your legally adopted children. Adopted children have the same coverage as children born to you or your spouse, whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption;
   - Your stepchildren;
   - Non-emancipated foster children. Emancipation is defined as the age of 18 unless specifically stated in the court order;
   - Non-emancipated children for whom either you or your spouse has been appointed legal guardian; and
   - Children for whom the plan has received a Qualified Medical Child Support order. The child must be named as your alternate recipient in the order.
3. **Children between the ages of 19 and 23 with approved student status**

   Dependents between the ages of 19 and 23 are eligible for continued coverage as long as they maintain their student status. Student coverage is not automatic. To initiate or continue coverage for your dependent, you are required to submit proof of eligibility within 31 days of the change in status/qualifying event.

   Student status required documents:
   - An "Affidavit of Student Status" form, accessed at *das.ohio.gov/forms* in the "Eligibility" section; and
   - A "Current Enrollment Verification Certificate" from the National Student Clearinghouse, *studentclearinghouse.org*, or a letter or official transcript from the school registrar must be submitted with the Affidavit of Student Status.

   If the proof of eligibility is provided timely, the dependent will remain on your vision coverage until he or she turns 23 or experiences a change in status/qualifying event, such as graduating from college or getting married.
4. **Unmarried children incapable of self-care**

   Unmarried children who are incapable of self-support due to a qualifying developmental disability, severe mental illness or physical handicap, whose disability began before age 23 and who are primarily dependent upon you are eligible for medical coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled for coverage, provided that the application is submitted within five years following loss of coverage.

   This coverage is not automatic. You must complete the applicable form for your third-party administrator of the Ohio Med PPO. A form for each third-party administrator can be obtained from your agency's human resources representative.

   Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

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

SPECIFIC BENEFIT INFORMATION

For plan specifics, see the EyeMed Vision Care Plan for Exempt Employees chart above.

EyeMed Vision Care is your new vision third-party administrator

EyeMed Vision Care Plan for Exempt Employees		
Benefit Frequency (Based on last date of service)	**In-Network**	**Out-of-Network**
Routine Exam/Frame/Lens	Once every 12 months	Once every 12 months
Service	**Your In-Network Cost**	**Your Out-of-Network Reimbursement***
Exam Dilation as necessary	$10 co-pay $0	Up to $25
Refraction	$0	
Retinal Imaging	Up to $39	N/A
Exam Options – Contact Lenses Standard Fit and Follow-Up Premium Fit and Follow-Up	 Up to $40 90% of retail price	 N/A
Frames	$0 copay, plus 80% of balance over $120	Up to $18
Standard Plastic Lenses		
Single Vision	$15 copay	Up to $25
Bifocal	$15 copay	Up to $35
Trifocal	$15 copay	Up to $52
Lenticular	$15 copay	Up to $62
Standard Progressive	$15 copay	Up to $52
Premium Progressives (Tier 1-4)	$15 copay	Up to $52
Standard Lens Options		
UV coating	$15	N/A
Tint (solid and gradient)	$15	N/A
Standard scratch resistance	$15	N/A
Standard polycarbonate	$0	Up to $0
Standard anti-reflective coating	$45	N/A
Premium anti-reflective coating (Tier 1/2)	$57/$68	N/A
Premium anti-reflective coating (Tier 3)	80% of retail price	N/A
Polarized	80% of retail price	N/A
Photocromatic/Transitions Plastic	$75	N/A
Other add-ons and services	80% of retail price	N/A
Contact Lenses**		
Conventional (Instead of lenses and frames)	$0 copay, plus 85% of balance over $125	Up to $125
Disposable (Instead of lenses and frames)	$0 copay, plus 100% of balance over $125	Up to $125
Medically necessary	$0	Up to $210
LASIK or PRK from US Laser Network	85% of retail price, or 95% of promotional price, whichever is less	N/A
Low Vision		
Supplemental Testing	Covered in full	Up to $125 allowance
Low Vision Aids	25% copay up to $1,000	25% copay up to $1,000 allowance

* You are responsible to pay the out-of-network provider in full at the time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the benefit will pay one-half of the amount payable for contact lenses for both eyes. Benefit allowances provide no remaining balance for future use within the same benefit frequency.

The EyeMed Insight network encompasses many providers. However, if you choose a non-network provider, out-of-network charges will apply.

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

eyemed.com
888-838-4033 / Group Number: 1016475

Exempt employees newly enrolled in the EyeMed vision plan will receive a welcome packet with two EyeMed ID cards. The EyeMed ID cards also can be obtained from the EyeMed website, *eyemed.com*, or mobile app. The ID cards are not required when using vision benefits.

ENROLLMENT

An enrollment packet will be mailed to you prior to your one-year anniversary. Coverage will be effective the first day of the month following the completion of one year of continuous state service, as long as you have submitted your enrollment within 31 days of your anniversary date. See the Benefits Enrollment Instructions on Page 7.

ADDITIONAL BENEFITS

Forecasting future financial needs can be challenging. Whether you are attempting to assess retirement goals or to ensure that your family is provided for if the unexpected happens, we understand your financial security is an especially important consideration. The benefit programs available through the State of Ohio offer a variety of financial assistance and can be tailored to your specific needs.

All benefits are subject to limitations and restrictions. Visit *das.ohio.gov/benefits* for more information about:

- Basic life insurance (exempt employees);
- Supplemental life insurance (exempt employees);
- Disability benefits;
- Workers' Compensation benefits;
- Flexible Spending Accounts (health care spending account and dependent care spending account); and
- Commuter Choice.

Life Insurance 29
Basic (exempt employees) 29
Supplemental (exempt employees) 30
Union Benefits Trust Open Enrollment (union-represented employees) 32
Disability 33
Workers' Compensation 34
Salary Continuation 35
Occupational Injury Leave 35
Flexible Spending Accounts 37
Health Care 37
Dependent Care 38
Commuter Choice 38

Basic and Supplemental Life Insurance (exempt employees)
Minnesota Life
866-293-6047
lifebenefits.com

Flexible Spending Accounts and Commuter Choice
WageWorks
855-428-0446
wageworks.com

Union Benefits Trust
614-508-2255 / 800-228-5088
benefitstrust.org

Life Insurance (FOR EXEMPT EMPLOYEES)

Basic Life Insurance

The State of Ohio provides basic life insurance coverage through Minnesota Life, including an occupational accidental death and dismemberment (OAD&D) benefit for work-related injuries.

COST

The state pays the total contributions for this benefit that is equal to your annualized rate of pay rounded up to the next highest $1,000. See the chart below.

Monthly Contributions per $1,000 of Basic Life Insurance Coverage			
	Employee Share	State Share	Total
Basic Life	$0	$0.105	$0.105
OAD&D	$0	$0.012	$0.012

ELIGIBILITY

Employees

Exempt full-time and part-time permanent employees, firefighters, judges and other elected officials serving fixed terms of office are offered basic life insurance following the completion of one year of continuous state service.

Dependents

Dependents are not eligible for exempt basic life insurance coverage.

SPECIFIC BENEFIT INFORMATION

The IRS requires you to be taxed on the value of employer-paid group basic life insurance coverage exceeding $50,000, known as "imputed income." This amount is based on the chart below and is reported to the IRS in Box 12 of your W-2 form. The imputed income bracket is based upon your age on the last day of your tax year and increases in five-year increments as you grow older. See the chart to the right.

Beneficiary Elections

Your beneficiary elections will apply to both your basic and supplemental life insurance benefits.

You may designate one or more beneficiaries for your basic and supplemental life benefits by visiting the Minnesota Life website at *lifebenefits.com*. Alternatively, you may submit a beneficiary form by mail to Minnesota Life. This form is available in the Forms section of the Benefits Administration website available at *das.ohio.gov/forms*.

ENROLLMENT

Enrollment in basic life insurance is automatic.

IRS Basic Life Imputed Income Chart Monthly Cost per $1,000 of Coverage in Excess of $50,000	
Age	Cost
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

Supplemental Life Insurance
(FOR EXEMPT EMPLOYEES)

Exempt full-time and part-time permanent employees, firefighters, judges and other elected officials serving fixed terms of office are eligible to purchase supplemental life insurance coverage provided by Minnesota Life.

COST

The coverage is entirely employee-paid; the state does not pay any contributions. Premiums depend on age and the amount of coverage purchased. If an employee or covered spouse experiences a change in an age bracket, the premium increase will be effective the following year (Jan. 1), regardless of the month or day of their birthday. See the chart on Page 31.

For 82 cents per month, you may purchase $7,000 worth of supplemental life insurance coverage for your dependent children, regardless of how many children you cover.

ELIGIBILITY

Employees

Exempt full-time and part-time permanent employees, firefighters, judges and other elected officials serving fixed terms of office are eligible for supplemental life insurance on their date of hire or promotion or thereafter during Open Enrollment.

Dependents

Spouses and eligible dependent children of exempt employees are eligible for exempt supplemental life insurance.

SPECIFIC BENEFIT INFORMATION

COVERAGE LEVELS

Employees

During Open Enrollment

- You may purchase up to eight times your annualized earnings, rounded to the next higher $10,000, not to exceed $600,000.
- You must provide evidence of insurability if you request an amount of insurance over the nonmedical limit – the lesser of two times your annualized earnings or $150,000.
- Coverage below the non-medical limit amount will be effective July 1, 2018.
- Coverage above the non-medical amount, which is subject to evidence of insurability (EOI), will be effective July 1, 2018 or the date EOI is approved by Minnesota Life (whichever is later). See Page 50 for plan contact information.

When initially eligible

- You may purchase up to eight times your annualized earnings, rounded to the next higher $10,000, not to exceed $600,000.
- You must provide evidence of insurability if you request an amount of insurance over the non-medical limit for new hires – the lesser of three times your annualized earnings or $500,000.
- Coverage below the non-medical limit amount will be effective once it is processed by Minnesota Life.
- Coverage above the non-medical amount, which is subject to evidence of insurability, will be effective the first of the month after your evidence of insurability has been approved. See Page 50 for plan contact information.

Dependents

During Open Enrollment and initial eligibility

To elect supplemental life insurance for your eligible dependents, you must be enrolled.

1. **Spouse**
   - You may purchase coverage for your spouse in $10,000 increments up to $40,000. Spousal coverage in excess of $10,000 requires your spouse to provide evidence of insurability.
2. **Children**
   - You may purchase coverage for your eligible dependant children younger than age 26 up to $7,000 for 82 cents per month, regardless of how many children you cover.

ENROLLMENT

Employees

- Enroll within 90 days of being hired or promoted;
- Enroll during the annual Open Enrollment period; or
- Enroll within 31 days of a change in status/ qualifying event.

Dependents

- Enroll your eligible dependents within 90 days of being hired or promoted;
- Enroll during the annual Open Enrollment period; or
- Enroll within 31 days of a change in status/ qualifying event.

How to Enroll in Supplemental Life

To enroll in supplemental life insurance, visit the Minnesota Life website at *lifebenefits.com*. For login instructions, see Page 50 under the Life Insurance section for exempt employees only. You also may obtain a supplemental life enrollment form on the Forms section of the Benefits Administration website at *das.ohio.gov/forms*.

Cancelling or Reducing Coverage

- You may cancel or reduce your employee or eligible dependent supplemental life insurance coverage at any time by submitting a written request to Minnesota Life.
- You are responsible for dropping your dependent's coverage when your child reaches age 26.
- Coverage will be cancelled or reduced effective the first day of the month after your request is received and processed by Minnesota Life. Once coverage is cancelled or reduced for either yourself and/or your dependents, evidence of insurability will be required for any future enrollment for supplemental life insurance, including during Open Enrollment and qualifying events. You may be required to submit medical documentation and your coverage election may be approved or rejected by Minnesota Life based upon medical underwriting results.

For questions regarding supplemental life insurance, contact Minnesota Life and provide group number 34301. See the Contacts section on Page 50 for more information.

Supplemental Life (Exempt Employee and Spouse)
Monthly per $10,000 of coverage

Age	Non-Smoker	Smoker
Younger than 25	$0.49	$0.64
25-29	$0.49	$0.64
30-34	$0.60	$0.64
35-39	$0.68	$0.95
40-44	$1.08	$1.45
45-49	$1.67	$2.42
50-54	$2.59	$3.73
55-59	$4.16	$5.54
60-64	$6.30	$8.49
65-69	$10.23	$15.24
70 and older	$17.34	$27.29

Union Benefits Trust Open Enrollment

(FOR UNION-REPRESENTED EMPLOYEES)

MAY 21 THROUGH JUNE 1, 2018
For the benefit year from July 1, 2018 through June 30, 2019

The Union Benefits Trust (UBT) Open Enrollment Guide and forms for union-represented employees are available at *benefitstrust.org* under **FORMS & INFO**.

As a union-represented State of Ohio employee, your benefits include:

- UBT Dental Plan, administered by Delta Dental of Ohio
- Choose from two vision plans, administered either by Vision Service Plan or EyeMed Vision Care
- Basic Life Insurance Plan, administered by Prudential Life Insurance
- Supplemental Life Plan, administered by Prudential Life Insurance
- Legal Services, administered by Hyatt Legal Services/MetLife
- Working Solutions: available to all, offered at no cost or enrollment required

COVERAGES FOR THE 2018-2019 BENEFIT YEAR:
New Dental Wellness Program, see your guide or the UBT website for details

Basic Life Insurance Plan:

- Look for your Benefits Summary from Prudential in August. It will show you your new Basic life coverage amount after the July 1 bargained wage increases; this also is a good time to review beneficiary information.

Supplemental Life Plan:

- During Open Enrollment, you may purchase or increase your coverage by two times your basic annual earnings or $150,000, whichever is less, without proof of good health, or up to eight times your basic annual earnings, or $600,000 whichever is less, with proof of good health.
- Coverage for your legal spouse and eligible children also is available.
- Mail your form to Prudential at the address on the form. Do not submit to your human resources office.

Hyatt Legal Plan:

- Mail your form to Hyatt at the address on the form. Do not submit to your human resources office.
- If you are cancelling the plan, you may do so only during the Open Enrollment period.

In preparation for Open Enrollment, union-represented state employees will receive two mailings in early May:

- UBT Open Enrollment Guide
- Prudential Supplemental Life mailer

For questions, call Customer Service, 1-800-228-5088 or 1-614-508-2255, between 8 a.m. and 5 p.m., or email *customerservice@benefitstrust.org*.

UNION BENEFITS TRUST

Disability Benefits

The State of Ohio offers eligible employees disability leave benefits. These benefits provide financial assistance in the event that you are unable to perform the duties of your position due to a non-work-related disabling illness, injury or condition for a period of more than 14* consecutive calendar days.

COST

The state pays the total contribution for the disability leave benefit. This program is offered at no cost to the employee.

ELIGIBILITY

Full-time permanent employees who have completed one year of continuous state service immediately prior to the date of the disabling condition are eligible.

Part-time permanent employees who have completed one year of continuous state service and have worked 1,500 or more hours within the 12 calendar months immediately preceding the date of the disabling condition also are eligible.

SPECIFIC BENEFIT INFORMATION

Covered Conditions

The following disabling illnesses, injuries or conditions may be considered for disability leave benefits:

- Non-work-related injury or illness;
- Mental health conditions treated by a licensed mental health provider; and/or
- Substance use conditions (an employee must be receiving ongoing treatment which prevents the employee from working).

Conditions that may not be Covered

Disability benefits may not be payable for the following:

- Work-related injury;
- Attempted suicide or a self-inflicted injury;
- Any illness or injury resulting from an act of war, declared or undeclared;
- Any illness or injury resulting from participation in a riot or insurrection;
- Untreated drug addiction or alcoholism;
- Any illness or injury incurred during the act of committing a felony;
- An illness occurring during the time an employee is under investigation for possible disciplinary action by their agency; or
- Any illness occurring after separation from state service.

Payment While on Disability Leave

Disability benefits are paid at 67 percent of the employee's base rate of pay, subject to a lifetime maximum of 12 months of eligibility* for the majority of state employees (whether the employee files a new, subsequent-related or subsequent-unrelated claim). The employer's and employee's share of the health, life and other insurance benefits will be paid by the employer during the period the employee is pending or receiving disability leave benefits. However, the employee is responsible for paying his or her portion of retirement contributions.

Disability Benefits may be Denied

- If you engage in any occupation for wage or profit;
- If you engage in an act of fraud or misrepresentation involving your disability claim;
- If you do not consult a licensed practitioner for necessary medical care;
- If you do not follow your prescribed treatment for your disabling condition;
- If you fail to notify the appointing authority of a change of address;
- If you are convicted of a felony; or
- If you have a mental health condition treated by a general practitioner or primary care physician.

For details, go to the Disability Coverage web page at *das.ohio.gov/disability*.

ENROLLMENT

Enrollment is automatic for eligible employees who have completed one year of continuous state service.

** Employees of the Auditor of State, Ohio Attorney General, Secretary of State and Treasurer of State subject to a collective bargaining agreement should refer to their applicable agreement.*

Workers' Compensation

Workers' compensation is a "no-fault" system that compensates employees for work-related injuries or illnesses.

COST

State agency contributions are determined by the Ohio Bureau of Workers' Compensation (BWC) per $100 of payroll for benefits offered by the BWC.

ELIGIBILITY

All state employees are eligible for benefits offered by the BWC.

SPECIFIC BENEFIT INFORMATION

When an Injury Occurs

Obtain medical care promptly. If emergency treatment is required, go immediately to the nearest emergency facility. Otherwise, the Managed Care Organization* can provide you with names of providers in your area.

Complete an Accident or Illness Report (Form ADM 4303). Your agency will forward the completed Form ADM 4303 to the Managed Care Organization, who will file the initial claim information with the BWC.

Your health care provider will forward all medical information regarding your claim to the Managed Care Organization who will contact you to gather additional information regarding your treatment, recovery and claim.

BWC will send you a letter assigning you a claim number. Retain and reference this number when contacting your agency, BWC, Managed Care Organization and your health care provider regarding your claim.

BWC will make an initial decision to approve or deny your claim and will notify you in writing.

Medical-only Claims

You may be eligible for a medical-only claim if you are unable to work for seven calendar days or less. If approved, the Managed Care Organization will pay authorized treatments directly related to your claim.

Lost Time Claims

If your attending physician determines that your injury or illness will prevent you from working for eight or more calendar days, you may be eligible to receive lost time benefits through the BWC. You and your attending physician will need to file a Request for Temporary Total Compensation (Form C-84). Your physician also will need to complete the Physicians Report of Work Ability Form (Form MEDCO-14). These forms are available on BWC's website at *bwc.ohio.gov*.

If approved, BWC will begin paying temporary total benefits accordingly:

- On the eighth day, if you are off work from eight to 14 days; or
- From the first day, if you are off work for 14 or more consecutive days;

BWC will pay you directly by electronic deposit to your bank account.

You cannot receive payment from the BWC for the same period you receive payment from your agency for Sick Leave, Disability, Salary Continuation or Occupational Injury Leave benefits. If this occurs, you will be responsible for reimbursing your agency for the benefits you received.

Temporary Total Compensation

If your claim is approved for lost time, you may receive temporary total compensation at 72 percent of your full weekly wages for up to 12 weeks.

If your injury or illness prevents you from working for more than 12 weeks, your temporary total compensation will be reduced to 66 2/3 percent of your average weekly wage.

** Check with your agency human resources representative to obtain the name and contact number of the Managed Care Organization assigned to your agency.*

Employer-Provided Benefits

Salary Continuation

This benefit provides the injured employee with 100 percent of his or her regular rate of pay in lieu of BWC temporary total compensation if an approved Workplace Injury Labor Management Approved Provider Committee (WILMAPC) provider is used within seven days of the injury and agency accident reporting guidelines are followed.

Bargaining unit employees should refer to their applicable collective bargaining agreement.

COST

Participating state agencies pay the total contribution of this benefit through their budget process.

ELIGIBILITY

Salary Continuation is available to full-time or part-time permanent employees.

The offices of the Auditor of State, Attorney General and Secretary of State do not participate in Salary Continuation. Also, employees covered by the Ohio State Troopers Association collective bargaining agreement are not eligible for Salary Continuation.

SPECIFIC BENEFIT INFORMATION

- In order to receive Salary Continuation, you must use a provider approved by the WILMAPC within seven days of your injury. To locate an approved WILMAPC provider, go to *das.ohio.gov/wilmapc* and click on the WILMAPC Approved Provider Panel link to search for a provider, or contact your human resources representative. If emergency treatment is required, go immediately to the nearest emergency facility and follow up with an approved WILMAPC provider within seven days of your injury to obtain benefits.
- Follow your agency's policy on reporting accidents and injuries. Failure to adhere to your agency accident reporting guidelines or policy when applying for Salary Continuation may result in denial of benefits.
- Complete an Accident or Illness Report (ADM 4303), located at *das.ohio.gov/forms*.
- Benefits are limited to a maximum of 480 hours.
- Once Salary Continuation benefits are exhausted, you may be eligible to receive lost time benefits from BWC. You will need to file a Request for Temporary Total Compensation (Form C-84) and your physician must complete the Physician's Report of Work Ability (Form MEDCO-14).
- Bargaining unit and exempt employees may appeal a denied Salary Continuation decision by completing the Salary Continuation and Occupational Injury Leave Appeal Form located at *das.ohio.gov/forms*. Instructions are located on the form.
- Appeals should be sent to the Ohio Department of Administrative Services' Office of Collective Bargaining within 20 days of the denial.
- Bargaining unit employees should refer to the appeal procedure in their collective bargaining agreement.
- For exempt employees, the decision by the Ohio Department of Administrative Services is final.
- Payments for Salary Continuation are included in your paycheck in accordance with state payroll processing timelines.

Occupational Injury Leave

This benefit provides the injured employee with 100 percent of his or her regular rate of pay in lieu of workers' compensation temporary total benefits if an approved Workplace Injury Labor Management Approved Provider Committee (WILMAPC) provider is used within seven days of the injury and agency accident reporting guidelines are followed.

Bargaining unit employees should refer to their applicable collective bargaining agreement.

COST

Participating state agencies pay the total contributions of this benefit through their budget process.

ELIGIBILITY

Occupational Injury Leave (OIL) is available to full-time or permanent part-time employees, who suffer a bodily injury in the line of duty inflicted by an inmate, client, patient, resident, youth or student, and is limited to specific agencies. You may contact your human resources representative or refer to your applicable collective bargaining agreement for specific information.

SPECIFIC BENEFIT INFORMATION

- In order to receive Occupational Injury Leave, you must use a provider approved by the WILMAPC within seven days of your injury. To locate an approved WILMAPC provider, go to *das.ohio.gov/wilmapc* and click on the WILMAPC Approved Provider Panel link to search for a provider or, contact your agency human resources representative. If emergency treatment is required, go immediately to the nearest emergency facility and follow up with an approved WILMAPC provider within seven days of your injury to obtain benefits.
- Follow your agency's policy on reporting accidents and injuries. Failure to adhere to your agency accident reporting guidelines or policy when applying for Occupational Injury Leave may result in denial of benefits.
- Complete an Accident or Illness Report (ADM 4303), located at *das.ohio.gov/forms*.
- Benefits are limited to a maximum number of hours determined by your bargaining unit. Non-bargaining unit employees have a maximum of 960 hours.
- Once Occupational Injury Leave benefits are exhausted, you may be eligible to receive lost time benefits from BWC. You will need to file a Request for Temporary Total Compensation (Form C-84) and your physician must complete the Physician's Report of Work Ability (Form MEDCO-14).
- Bargaining unit and exempt employees may appeal a denied Occupational Injury Leave decision by completing the Salary Continuation and Occupational Injury Leave Appeal Form located at *das.ohio.gov/forms*. Instructions are located on the form.
- Appeals should be sent to the Ohio Department of Administrative Services' Office of Collective Bargaining within 20 days of the denial.
- Bargaining unit employees should refer to the appeal procedure in their applicable collective bargaining agreement.
- For exempt employees, the decision by the Ohio Department of Administrative Services is final.
- Payments for Occupational Injury Leave are included in your paycheck in accordance with state payroll processing timelines.

Disability Advancement

Disability advancement is a monetary advancement of disability benefits that an injured worker can receive while awaiting BWC approval of his or her workers' compensation claim.

COST

State agencies pay the total contributions of this benefit through their budget process.

ELIGIBILITY

Disability advancement is only available to full-time and part-time permanent employees whose initial claim is denied by the BWC and are appealing the decision. If you do not intend to appeal, you may file for disability benefits within 20 days of the denial order.

SPECIFIC BENEFIT INFORMATION

- You may receive the disability advancement for a maximum of 12 weeks. If your workers' compensation claim is approved through the appeal process or by a settlement, you will be required to pay back all of the money that has been advanced, regardless of the amount received from BWC or the settlement.
- To file for disability advancement, complete the disability application and disability agreement. Submit the forms with your denial order to your human resources representative within 20 days of the denial notification.

These forms are located at *das.ohio.gov/forms*.

Leave Buy Back

Some bargaining unit employees have the option of buying back leave time that was used while waiting for a workers' compensation claim to be approved. See your applicable collective bargaining agreement to determine your eligibility.

COST

The state does not pay any contribution. The employee pays the total contribution of this benefit.

ELIGIBILITY

This benefit is only available to certain bargaining unit employees. Refer to your applicable collective bargaining agreement.

SPECIFIC BENEFIT INFORMATION

You may buy back leave time either with or without a BWC wage advancement agreement.

A wage advancement agreement is a contract between you and your employer that states the amount of leave time that you will buy back and is available at BWC's website at *bwc.ohio.gov*.

Flexible Spending Accounts

Flexible Spending Accounts (FSA) are tax-favored accounts that provide the opportunity for eligible permanent employees to defer funds on a pre-tax basis to pay for eligible expenses throughout the calendar year.

Health Care Spending Account

The health care spending account (HCSA), administered by WageWorks, is a tax-favored account that provides the opportunity to defer on a pre-tax basis a minimum of $240 and up to a maximum of $2,500 per calendar year into an account to pay for eligible medical expenses not paid by medical, vision or dental plans.

COST

The State of Ohio pays the $3.30 monthly administrative fee on behalf of participating employees.

ELIGIBILITY

Permanent full-time or permanent part-time employees who have successfully completed their initial probationary period, if applicable, and have sufficient earnings to cover the election amount are eligible to participate.

SPECIFIC BENEFIT INFORMATION

It is not necessary to be enrolled in the Ohio Med PPO Plan to participate in an HCSA. If your spouse also is a state employee, each of you may participate in an HCSA as separate individuals.

Carry Over

HCSA participants who have more than $50 and up to $500 remaining in their account on Dec. 31 may carry over that amount to the next plan year. Any amount less than $50 or more than $500 will be subject to the IRS Forfeiture Rule.

IRS Forfeiture Rules

Federal regulations provide certain forfeiture rules. For example, at the end of the month of your employment termination, any unspent HCSA or DCSA balance will be forfeited.

Changes in Coverage

According to IRS regulations, a mid-year change can be made to the HCSA election if the employee experiences a change in status/qualifying event. However, the proposed change must be consistent with the type of change experienced. Contributions and benefit changes must be a result of the change in status/qualifying event. The time frame for notification is within 31 days of the change in status/qualifying event and will take effect the first of the month following the receipt of the "Flexible Spending Account Change Form" and the supportive documentation. The form is available at *das.ohio.gov/forms*.

ENROLLMENT

- Enroll within 31 days of the hire date or change in status/qualifying event, if there is no probationary period; or
- Enroll within 31 days of successfully completing probation, if applicable.

Enrollment forms are located at *das.ohio.gov/forms*.

If an employee does not enroll within the time frames, other opportunities to enroll are:

- During the annual Flexible Spending Accounts Open Enrollment period, held in the fall; or
- Following a change in status/qualifying event.

These benefits require annual enrollment.

Dependent Care Spending Account

The dependent care spending account (DCSA), administered by WageWorks, is a tax-favored account that provides the opportunity to defer on a pre-tax basis a minimum of $240 and up to a maximum of $5,000 per calendar year (depending on tax filing status) into an account to pay for eligible child care, dependent care or eldercare expenses.

COST

The State of Ohio pays the $3.30 monthly administrative fee on behalf of participating employees.

ELIGIBILITY

Permanent full-time or permanent part-time employees who have sufficient earnings to cover the election amount and a qualifying dependent(s). Spouses, regardless whether they are state employees, may participate in a DCSA as separate individuals but cannot exceed the $5,000 IRS annual maximum per family.

SPECIFIC BENEFIT INFORMATION

Federal regulations provide certain forfeiture rules. For example, at the end of the month of your employment termination, any unspent HCSA or DCSA balance will be forfeited.

Changes in Coverage

According to IRS regulations, a mid-year change can be made to the DCSA election if the employee experiences a change in status/qualifying event. However, the proposed change must be consistent with the type of change experienced. Contributions and benefit changes must be a result of the change in status/qualifying event. The time frame for notification is within 31 days of the change in status/qualifying event and will take effect the first of the month following the receipt of the "Flexible Spending Account Change Form" and the supportive documentation. The form is available at *das.ohio.gov/forms*.

ENROLLMENT

Enroll within 31 days of the hire date or change in status/qualifying event. Enrollment forms are located at *das.ohio.gov/forms*.

If an employee does not enroll within the time frames, other opportunities to enroll are:

- During the annual Flexible Spending Accounts Open Enrollment period held in the fall; or
- Following a change in status/qualifying event.

These benefits require annual enrollment.

For more detailed information about Flexible Spending Accounts, visit *das.ohio.gov/flexiblespendingaccount*.

Commuter Choice Program

The Commuter Choice Program, administered by WageWorks, covers two types of commuting expenses:

- Transportation expenses, which include qualified fares for riding buses, trains, subways, ferries and other types of mass transportation or van pools; and
- Parking expenses which include the cost of parking at or near your place of work or at or near a place from which you commute to work by mass transit, such as a park-and-ride lot.

COST

The employee pays the monthly administrative fee for the Commuter Choice Program which is $3.95 on an after-tax basis.

ELIGIBILITY

All State of Ohio employees are eligible for participation in the Commuter Choice Program.

SPECIFIC BENEFIT INFORMATION

When you enroll in Commuter Choice for eligible transportation expenses, you are authorizing the third-party administrator to purchase your public transportation fare passes (e.g., bus pass) and van pool passes, directly from your transportation provider. For more information, visit *das.ohio.gov/commuterchoiceprogram*.

The 2018 IRS monthly allowable dollar limit for transit is $260. When you enroll for the Commuter Choice transit benefit, the fare pass will be delivered directly to your mailing address.

The 2018 IRS monthly allowable dollar limit for parking is $260. When you enroll for the Commuter Choice parking benefit, WageWorks will pay your parking service directly.

Should your parking and/or transit expenses exceed the IRS monthly allowable dollar limit, you may have additional dollars withheld on an after-tax basis to pay your expenses that exceed the IRS dollar limit.

ENROLLMENT

Employees may enroll in the Commuter Choice Program at any time. There is no need to wait for Open Enrollment.

Enrollment must be made before the fifth of the month prior to the effective month (e.g., March 5 for the effective date of April 1).

Employees who wish to begin participating in the Commuter Choice Program may do so by accessing the WageWorks website at *wageworks.com*.

LEGAL NOTICES

Notice of Privacy Practices 39

Notice of Initial COBRA Rights 41

Costs of Continuation Coverage 42

Special Enrollment Rights Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) 43

Women's Health and Cancer Rights Act of 1998 43

Newborns' and Mothers' Health Protection Act 43

Patient Protection Disclosure 44

Creditable Coverage Disclosure 44

Notice Regarding Wellness Program 45

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) 46

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

NOTICE OF PRIVACY PRACTICES

Effective April 1, 2018

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

PLEASE REVIEW IT CAREFULLY.

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

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

If you have questions about this notice, please contact the Plan's HIPAA Privacy Contact listed on Page 41.

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

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

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

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

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

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

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

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

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

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

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

E. **Victims of Abuse, Neglect, or Domestic Violence.** The Plan may disclose medical information to a government authority, including a social service or protective agency if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence.

F. **Health Oversight Activities.** The Plan may disclose medical information to a health oversight agency for oversight activities authorized by law, such as: overall health care system monitoring, monitoring the conduct of government programs, and monitoring to ensure compliance with civil rights laws.

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

H. **Law Enforcement Purposes.** The Plan may disclose medical information to law enforcement officials for law enforcement purposes including investigation of a crime or to identify or locate a suspect, fugitive, material witness or missing person.

I. **Specialized Government Functions.** The Plan may disclose medical information to authorized federal officials for the purposes of intelligence, counterintelligence, and other national security activities authorized by law.

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

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

L. **Workers' Compensation.** The Plan may disclose medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

M. **Coroners, Medical Examiners, and Funeral Directors**. The Plan may disclose medical information to a coroner or medical examiner to, for example, identify a deceased person or determine the cause of death. The Plan may also disclose medical information about patients to funeral directors as necessary to carry out their duties.

N. **Business Associates.** The State contracts with parties who provide necessary services for the operation of its plans. For example, the Plan is assisted in its operations by third party administrators. These persons who assist the Plan are called business associates. At times, the Plan may use and disclose PHI so they can provide services. The Plan will require that any business associates who receive PHI safeguard the privacy of that information.

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

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

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

4. Changes to Existing Laws

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

Your Legal Rights

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

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

The Plan is not required to agree to your request. To request restrictions on the use or disclosure of your PHI, you must make your request in writing to the Plan's HIPAA Privacy Contact listed on Page 41. 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 on Page 41. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. After the Plan receives your request, the information may be forwarded to your health plan. As a result, additional reasonable information may be required from you by your plan to process the request.

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

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

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

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

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

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

This Notice Is Subject To Change

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

Whom to Contact

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

To file a complaint with the Secretary of the 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:

DAS -- HIPAA Privacy Contact
Greg Pawlack
30 E. Broad St., 27th Floor
Columbus, Ohio 43215

614-466-6205; email: *gregory.pawlack@das.ohio.gov*

NOTICE OF INITIAL COBRA RIGHTS

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

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

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

Qualifying Events

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

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

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

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

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

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

Length of Continuation Coverage

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

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

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

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

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

COST OF CONTINUATION COVERAGE

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

Termination of Continuation Coverage

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

- Your employer ceases to provide any group health plan to any of its employees;
- Any required premium for continuation coverage is not paid in a timely manner;
- A qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is

satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996.

- A qualified beneficiary becomes entitled to Medicare after the qualifying event except when the qualifying event is loss of retiree coverage due to the employer's bankruptcy;
- A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
- A qualified beneficiary notifies iTEDIUM, Inc. that they wish to cancel COBRA continuation coverage.
- A qualified beneficiary participates in activity which would otherwise allow the Plan to terminate an active employee's coverage (e.g. submission of a fraudulent claim).

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

For More Information

For more information on general Plan terms contact State of Ohio. For more information about COBRA contact iTEDIUM, Inc. toll free at (877) 682-6272. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit *www.dol.gov/ebsa*. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit *www.healthcare.gov*.

SPECIAL ENROLLMENT RIGHTS PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage. The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

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

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your Plan Administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at 312-353-0900.

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

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

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

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

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

If you have any questions or would like more information about the State of Ohio's WHCRA benefits, contact Employee Benefits Customer Service at 614-466-8857 (option 2) or 800-409-1205 (option 2).

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under the provisions of The Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. However, federal law generally does not prohibit the mother's or newborn's

attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PATIENT PROTECTION DISCLOSURE

The Ohio Med PPO 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 below for Aetna, Anthem, and Medical Mutual of Ohio.

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

You do not need prior authorization from Aetna, Anthem, Medical Mutual of Ohio, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact: Aetna at (1-800-949-3104); Anthem at (1-844-891-8359); or, Medical Mutual of Ohio at (1-800-822-1152).

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 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 OptumRx is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct.15 to Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

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

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

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

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

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

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

For further information, contact:

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

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

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy

of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit: *medicare.gov*.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at: *socialsecurity.gov* or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

NOTICE REGARDING WELLNESS PROGRAM

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

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

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

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

Protections from Disclosure of Medical Information

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the health coaching staff at Sharecare, in order to provide you with services under the wellness program.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, contact;

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

614-728-5478; email: *beth.kim@das.ohio.gov*

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**IOWA – Medicaid**
Website: *myalhipp.com* Phone: 1-855-692-5447	Website: *dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp* Phone: 1-888-346-9562
ALASKA – Medicaid	**KANSAS – Medicaid**
The AK Health Insurance Premium Payment Program Website: *myakhipp.com* Phone: 1-866-251-4861 Email: *customerservice@myakhipp.com* Medicaid Eligibility: *dhss.alaska.gov/dpa/pages/medicaid/default.aspx*	Website: *kdheks.gov/hcf* Phone: 1-785-296-3512
ARKANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: *myarhipp.com* Phone: 1-855-MyARHIPP (855-692-7447)	Website: *chfs.ky.gov/dms/default.htm* Phone: 1-800-635-2570
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**LOUISIANA – Medicaid**
Health First Colorado Website: *healthfirstcolorado.com* Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: *colorado.gov/hcpf/child-health-plan-plus* CHP+ Customer Service: 1-800-359-1991/State Relay 711	Website: *dhh.louisiana.gov/index.cfm/subhome/1/n/331* Phone: 1-888-695-2447
FLORIDA – Medicaid	**MAINE – Medicaid**
Website: *flmedicaidtplrecovery.com/hipp* Phone: 1-877-357-3268	Website: *maine.gov/dhhs/ofi/public-assistance/index.html* Phone: 1-800-442-6003 TTY: Maine relay 711
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: *dch.georgia.gov/medicaid* Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: *mass.gov/eohhs/gov/departments/masshealth* Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: *in.gov/fssa/hip* Phone: 1-877-438-4479 All other Medicaid Website: *indianamedicaid.com* Phone 1-800-403-0864	Website: *mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp* Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: *dphhs.mt.gov/montanahealthcareprograms/hipp*
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: *dhhs.ne.gov/children_family_services/accessnebraska/pages/accessnebraska_index.aspx*
Phone: 1-855-632-7633
Lincoln: 1-402-473-700
Omaha: 1-402-595-1178

NEVADA – Medicaid

Medicaid Website: *dwss.nv.gov*
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: *dhhs.nh.gov/oii/documents/hippapp.pdf*
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

NEW JERSEY – Medicaid and CHIP

Medicaid Website: *state.nj.us/humanservices/dmahs/clients/medicaid*
Medicaid Phone: 609-631-2392
CHIP Website: *njfamilycare.org/index.html*
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: *health.ny.gov/health_care/medicaid*
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: *dma.ncdhhs.gov*
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: *nd.gov/dhs/services/medicalserv/medicaid*
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: *insureoklahoma.org*
Phone: 1-888-365-3742

OREGON – Medicaid

Website: *healthcare.oregon.gov/pages/index.aspx*
www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: *dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm*
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: *www.eohhs.ri.gov*
Phone: 1-855-697-4347

SOUTH CAROLINA – Medicaid

Website: *scdhhs.gov*
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: *dss.sd.gov*
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: *gethipptexas.com*
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: *medicaid.utah.gov*
CHIP Website: *health.utah.gov/chip*
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: *greenmountaincare.org*
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: *coverva.org/programs_premium_assistance.cfm*
Medicaid Phone: 1-800-432-5924
CHIP Website: *coverva.org/programs_premium_assistance.cfm*
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: *hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program*
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: *mywvhipp.com*
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: *dhs.wisconsin.gov/publications/p1/p10095.pdf*
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: *wyequalitycare.acs-inc.com*
Phone: 307-777-7531

To see if any other states have added a premium assistance program since Jan. 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

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

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

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.

Biometric Screening: A private screening with a health professional that provides a snapshot of your health. The screening includes cholesterol (total), HDL, LDL, blood glucose, blood pressure, height, weight and waist circumference.

Change in Status/Qualifying Event: A change in your life that allows you to enroll or make an adjustment to your existing coverage. Examples include marriage, divorce, birth or adoption of a child, or a change in job status for you or a dependent.

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

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

Covered Person: The employee, the employee's spouse and/or dependent children who are eligible and enrolled under your health care plan.

Covered Services: Those services and supplies provided for the purpose of preventing, diagnosing or treating a medical condition, behavioral disorder, psychological injury or substance use addiction for which the plan will provide benefits.

Deductible: The amount you pay for eligible expenses each plan year before the plan begins to pay anything. This does not apply to preventive services covered at 100 percent.

Dependent(s): A spouse and/or an eligible child or children.

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 or Contribution: The portion of the total premium that you pay through pre-tax payroll deductions for your coverage.

Exempt Employee: An appointment to a position not represented by a labor union. Employees are usually exempt from union representation because they are supervisors, in positions of a confidential or fiduciary nature or not in permanent appointments.

Evidence of Insurability (EOI): An application process in which information on the condition of one's health or a dependent's health is provided in order to be considered for certain types of insurance coverage.

Flexible Spending Accounts (FSA): A type of savings account that provides the account holder with specific tax advantages. The account allows employees to contribute a portion of their pre-tax earnings to pay for qualified expenses, such as for medical or dependent care. The two types of FSAs are health care spending accounts and dependent care spending accounts.

Out-of-Pocket Maximum: The cap or maximum amount you pay for eligible out-of-pocket health care expenses during the plan year. After your out-of-pocket expenses reach the maximum, the plan pays 100 percent of any additional eligible expenses for the remainder of the plan year. There is a separate out-of-pocket maximum for prescription drugs.

Patient Protection and Affordable Care Act (also known as the Affordable Care Act or PPACA or simply ACA): The health reform legislation passed by Congress and signed into law in March 2010 by the president of the United States.

Preferred Provider Organization (PPO): A PPO is a medical plan that offers benefits at both network and non-network levels. When you enroll in the Ohio Med PPO, you may visit any doctor and receive benefits. However, the benefit is greater when you use network providers, but less when you use providers who are not part of the network.

Service Hours: Service hours include any hour for which an employee receives or is entitled to payment for performing their job duties for the State of Ohio. These hours also include each hour for which an employee is paid or entitled to payment due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence, but does not include hours that relate to Workers' Compensation or unemployment compensation, volunteer hours or a federal work-study program.

State Share or Contribution: The portion of the total premium the State of Ohio pays to provide its employees with coverage.

Summary of Benefits and Coverage (SBC): A requirement of the Patient Protection and 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 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. For full details, visit *das.ohio.gov/benefits*.

Third-Party Administrator (TPA): An organization or company that processes claims and other aspects of employee benefits plans on behalf of an employer. For example, Aetna, Anthem and Medical Mutual are the third-party administrators of the Ohio Med PPO.

Total Premium: The combination of the employee contribution and the state contribution.

Union-Represented Employee: Also known as a Bargaining Unit Employee, is represented by a labor union and covered by the terms of a collective bargaining agreement.

Well-Being 5 Survey: A confidential questionnaire that assesses your physical, emotional, financial and social health and how your lifestyle habits affect your overall well-being.

Health and Other Benefits Contacts

ALL EMPLOYEES

Medical
Aetna
800-949-3104
aetnastateohioemployee.com
Group Number: 285507

Anthem
844-891-8359
enrollment.anthem.com/stateofohio
Group Number: 004007521

Medical Mutual of Ohio
800-822-1152
stateofohio.medmutual.com
Group Number: 228000

Prescription Drug
OptumRx
866-854-8850
optumrx.com
Rx Group Number: STOH

Behavioral Health and Substance Use
Optum Behavioral Solutions
800-852-1091
liveandworkwell.com
Website Access Code: 00832
Group Number: 1507

Ohio Employee Assistance Program
800-221-6327
ohio.gov/eap

Take Charge! Live Well!
Sharecare
866-556-2288
ohio.gov/tclw
Click the Sharecare website button.

24-Hour Nurse Advice Line
Sharecare
866-556-2288, option 1

Flexible Spending Accounts and Commuter Choice
WageWorks
855-428-0446
wageworks.com

EXEMPT EMPLOYEES ONLY

Dental
Delta Dental of Ohio
800-524-0149
deltadentaloh.com
Delta Dental PPO
Group Number: 9273-0001

Vision
EyeMed Vision Care
888-838-4033
eyemed.com
Group Number: 1016475

Life Insurance
Basic Life Insurance and Supplemental Life Insurance
Minnesota Life, a Securian company
866-293-6047
lifebenefits.com
Group Number: 34301
Initial logon credentials for life insurance: The initial user ID is "**OH**" plus your State of Ohio User ID. The initial password is your date of birth (MMDDYYYY) plus the last four digits of your Social Security number.

UNION-REPRESENTED EMPLOYEES ONLY

Union Benefits Trust
614-508-2255
800-228-5088
website: *benefitstrust.org*
email:
customerservice@benefitstrust.org

The websites of the Union Benefits Trust (UBT) vendors listed below can be accessed through the UBT website.

Dental
Delta Dental of Ohio
877-334-5008
Group Number: 1009

Vision
Vision Service Plan (VSP)
800-877-7195
Group Number: 12022914

EyeMed Vision Care
866-723-0514
Group Number: 9674813

Life Insurance
Prudential Life Insurance
800-778-3827
844-533-4UBT (4828)
Group Number: LG-01049

Legal Services
Hyatt Legal Services
800-821-6400
Group Number: 4900010

ALL EMPLOYEES

Ohio Department of Administrative Services

Employee Benefits Customer Service

614-466-8857, option 2 or
800-409-1205, option 2

email:
mybenefits@das.ohio.gov

website: *das.ohio.gov/benefits*

TIP:

When placing a call, please ensure you have the documentation you might need during the call:

- Group Number
- State of Ohio User ID
- Explanation of Benefits if call is regarding a claim.

Save the Dates

2018 SAVE THE DATES

May
Open Enrollment begins May 21

June
Open Enrollment ends June 1
Benefit year ends June 30

July
New benefit year begins July 1

October
Flexible Spending Accounts Open Enrollment begins Oct. 15 and ends Oct. 26

December
Use your remaining Flexible Spending Accounts money by Dec. 31

2019 SAVE THE DATES

January
New Flexible Spending Accounts plan year begins Jan. 1

February
National Wear Red Day is Feb. 1

March
2018 Flexible Spending Accounts claims deadline is March 31

May
Open Enrollment period occurs

June
Benefit year ends June 30

July
New benefit year begins July 1

OhioDAS
SERVICE · SUPPORT · SOLUTIONS
DEPARTMENT OF ADMINISTRATIVE SERVICES

Ohio Department of Administrative Services
Human Resources Division
30 E. Broad St., 28th Floor
Columbus, OH 43215