

# MyBenefits

FOR STATE OF OHIO EMPLOYEES / JULY 1, 2020 – JUNE 30, 2021

**OPEN ENROLLMENT  
MAY 18–29, 2020**



## **INSIDE THE GUIDE:**

- **Open Enrollment Checklist (Page 7)**
- **New for the upcoming benefit year:**
  - **Ohio Med PPO: Changes to your copays, deductibles, and out-of-pocket maximums (Page 16)**
  - **Take Charge | Live Well (Pages 24-25)**
    - **Wellness Program gets a new brand**
    - **To be managed by Virgin Pulse beginning July 1, 2020**
    - **New wellness incentives: Earn more rewards than ever before**



Department of  
Administrative Services

## CONTENTS

Enrollment Periods . . . . .	4
Changes for Benefit Year 2021 . . . . .	5
Benefits Enrollment Instructions. . . . .	6
Open Enrolment Checklist . . . . .	7
Medical Coverage. . . . .	8
Save Smart with a Health Savings Account	12
Comparing Medical Plan Options . . . . .	13
Medical Care Comparison – Where to Go . . . . .	13
Ohio Med PPO Contributions . . . . .	14
Ohio Med HDHP Contributions. . . . .	15
In-Network and Out-of-Network Costs. . . . .	16
Preventive Care . . . . .	17
Telehealth – LiveHealth Online. . . . .	18
Cost-Saving Tools . . . . .	19
The Best Care Starts With You . . . . .	20
Prescription Drug Benefits . . . . .	21
Behavioral Health Benefits . . . . .	23
Ohio Employee Assistance Program. . . . .	23
Take Charge   Live Well . . . . .	24
Dental . . . . .	26
Vision . . . . .	28
Life Insurance . . . . .	30
Basic Life Insurance. . . . .	30
Supplemental Life Insurance. . . . .	31
Disability Benefits. . . . .	33
Workers’ Compensation . . . . .	34
Flexible Spending Accounts . . . . .	37
Health Care Spending Account. . . . .	37
Dependent Care Spending Account . . . . .	39
Commuter Choice Program . . . . .	39
Legal Notices . . . . .	40
Glossary . . . . .	48
Health and Other Benefits Contacts . . . . .	50





## THANK YOU FOR YOUR COMMITMENT TO PUBLIC SERVICE

Dear Colleague:

Thank you for choosing a career in public service. Each day you make Ohio a better place by delivering exceptional, efficient services.

In addition to offering a rewarding career, the State of Ohio provides an array of benefit plans and programs designed to encourage the well-being of you and your family.

The State offers a comprehensive and quality health plan, Ohio Med, offered in two plan designs: Ohio Med PPO and Ohio Med HDHP. Get faster, more convenient care through telehealth services. Take advantage of a Limited Purpose Flexible Spending Account, or an enhanced new wellness program that offers employees and spouses more opportunities for rewards than ever before.

This guide provides the information you need to choose the appropriate services to suit your needs and walks you through the coverage selection process. Consider taking advantage of all of the benefits programs available to you and your family. We hope you find it a useful tool.

Thank you for all you do to serve our state every day.

**Mike DeWine**

Governor  
State of Ohio

**Matt Damschroder**

Director  
Ohio Department of Administrative Services

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

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Ohio Department of Medicaid

## ABOUT YOUR STATE OF OHIO BENEFITS

### Benefits Provided by the State of Ohio

Your health benefits include medical, prescription drug, behavioral health, dental, vision, and the wellness program – known as Take Charge | Live Well. The benefit year runs from July 1 through June 30 during which services are rendered and your deductible and coinsurance are accumulated.

### State of Ohio Health Plans are Self-funded

All State of Ohio health plans are self-funded programs. This means 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 to the fund increase. Increased medical costs may cause an increase in the contribution amounts needed for future years.

**Employee Contributions + State Contributions =  
TOTAL CONTRIBUTION AVAILABLE TO PAY CLAIMS**



## ENROLLMENT PERIODS

### SPRING OPEN ENROLLMENT

**MAY 18–29, 2020**

*Medical, Dental, Vision, and Supplemental Life Insurance*

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

- Medical, which includes Behavioral Health, Prescription Drug, and Wellness
- Dental
- Vision
- Supplemental Life Insurance

This guide informs you and your family about these benefits available this coming benefit year, which begins July 1, 2020. 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 18 through Friday, May 29**. If you already are enrolled in benefits:

1. Review your Benefits Summary by logging into [myohio.gov](http://myohio.gov) and clicking **My Workspace** to access benefit information for you and any dependents.
2. Ensure any dependents still meet the eligibility requirements by visiting [das.ohio.gov/eligibilityrequirements](http://das.ohio.gov/eligibilityrequirements).

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

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

Any dependent who is pending approval during Open Enrollment will not be enrolled until the required documentation is received by your agency or the Ohio Department of Administrative Services. Documentation must be submitted by July 31, 2020, for these dependents to be enrolled in coverage. It is recommended that you submit all required documentation as soon as possible.

### FALL OPEN ENROLLMENT

**October 19-30, 2020**

*Flexible Spending Accounts*

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

- Health Care Spending Account
- Limited Purpose FSA
- Dependent Care Spending Account

The Flexible Spending Accounts Open Enrollment is administered by WageWorks.

### ENROLLMENT FOR NEW HIRES

**Employees Hired After July 1**

Eligible new employees may enroll in the medical plan within 31 days of your hire date or you must wait for the next Open Enrollment period or until you experience a change in status/qualifying event. Eligible employees are offered dental and vision benefits after one year of continuous service. Supplemental life insurance is available upon hire or Open Enrollment.

### Union Benefits Trust

Open Enrollment for union-represented employees wanting to enroll in dental, vision, and/or life insurance is managed by Union Benefits Trust.

- The Union Benefits Trust (UBT) benefits plans for union-represented employees are available at [benefittrust.org](http://benefittrust.org)
- For questions, call UBT at 800-228-5088 or email [customerservice@benefittrust.org](mailto:customerservice@benefittrust.org)

## CHANGES FOR BENEFIT YEAR 2021

Copays, deductibles, and out-of-pocket costs for the Ohio Med PPO and Ohio Med HDHP are detailed throughout the guide. Below is a chart that highlights the changes for the Benefit Year 2021.

OUT-OF-POCKET CHANGES FOR BENEFIT YEAR 2021 (JULY 1, 2020 – JUNE 30, 2021)	
BENEFIT DESCRIPTION	CHANGES
<b>Ohio Med HDHP with HSA</b>	
Employer Contribution to HSA	\$1,000 Single/\$2,000 Family
<b>Ohio Med PPO</b>	
<b>MEDICAL and BEHAVIORAL HEALTH</b>	
Deductible	\$400 Single/\$800 Family in-network; \$800 Single/\$1,600 Family out-of-network
Out of Pocket Maximum	\$2,500 Single/\$5,000 Family in-network; \$5,000 Single/\$10,000 Family out-of-network
Office Visit Copay	\$30 in-network; \$50 out-of-network
Specialist Copay	\$35 in-network; \$55 out-of-network
Urgent Care Copay	\$40 in-network; \$60 out-of-network
Emergency Room Copay	\$150 in-network or out-of-network
<b>PRESCRIPTION DRUGS</b>	
Preferred Brand Name, 30 Days at Retail	\$40.00
Preferred Brand Name, 30 Days at Specialty Pharmacy	\$40.00
Preferred Brand Name, 90 Days at Retail	\$120.00
Preferred Brand Name, 90 Days at Mail	\$100.00
Non-Preferred Brand Name, Generic Unavailable, 30 Days at Retail	\$75.00
Non-Preferred Brand Name, Generic Unavailable, 30 Days at Specialty Pharmacy	\$75.00
Non-Preferred Brand Name, Generic Unavailable, 90 Days at Retail	\$225.00
Non-Preferred Brand Name, Generic Unavailable, 90 Days at Mail	\$187.50
Non-Preferred Brand Name, Generic Available, 30 Days at Retail	\$75.00 plus the difference between the cost of the brand name and generic drug
Non-Preferred Brand Name, Generic Available, 30 Days at Specialty Pharmacy	\$75.00 plus the difference between the cost of the brand name and generic drug
Non-Preferred Brand Name, Generic Available, 90 Days at Retail	\$225.00 plus the difference between the cost of the brand name and generic drug
Non-Preferred Brand Name, Generic Available, 90 Days at Mail	\$187.50 plus the difference between the cost of the brand name and generic drug
Prescription Out-of-Pocket Maximum	\$3,500 Single/\$7,000 Family
<b>WELLNESS PROGRAM</b>	
Incentives	Earn up to \$550 Single/\$1,100 Employee and Spouse



### Take Charge | Live Well Gets New Brand, Administrator

Take Charge | Live Well – the State’s wellness program – is launching a new brand, including a new logo. In addition, the Take Charge | Live Well program will have a new third-party administrator, Virgin Pulse, effective July 1, 2020. The Take Charge | Live Well program is available to employees and spouses enrolled in the State of Ohio medical plan. See Pages 24-25 for details.

## 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](http://myOhio.gov) or via paper enrollment.

If you are a new employee who has not already received your OH|ID Workforce User ID in a letter or email, contact your agency human resources representative.

If you have not obtained your password for [myOhio.gov](http://myOhio.gov), contact the OAKS Help Desk by calling toll-free, 800-409-1205, option 1, or email [oaks.helpdesk@das.ohio.gov](mailto:oaks.helpdesk@das.ohio.gov).

#### A. ONLINE ENROLLMENT

Login instructions for [myOhio.gov](http://myOhio.gov):

- Go to [myOhio.gov](http://myOhio.gov)
- Enter your OH|ID Workforce User ID and password
- Click the **My Workspace** tab in the top menu
- Click the **myBenefits** link under Self Service Quick Access heading
- Click the **Benefits Summary** link
- Click the **Enroll in Benefits** button and make the necessary changes or updates

#### Benefits System Availability via [myOhio.gov](http://myOhio.gov)

##### Non-Payday Week

Monday – Thursday..... Available 24 hours/day

Friday..... All day until 7 p.m.

Saturday and Sunday..... Unavailable

##### Payday Week

Monday – Friday ..... Available 24 hours/day

Saturday ..... All day except 4 to 6 p.m.

Sunday..... Unavailable

**Deadline is May 29, 2020:** Make and submit your selections through [myOhio.gov](http://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 if you have a valid email address in the system.

#### B. PAPER ENROLLMENT\*

Obtain a paper Benefit Enrollment/Change Form (Form ADM 4717) on the Benefits Administration website at [das.ohio.gov/forms](http://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 by 2 p.m. on May 29. Your agency representative needs time to enter your elections before 5 p.m.

\*Paper enrollment is only available to those who are choosing the Ohio Med PPO plan option. Enrollment in the Ohio Med HDHP option must be completed online.

#### Union-Represented Employee Dental and Vision Enrollment

Union-represented employees must complete separate vision and dental forms; they must also be submitted by the deadline stated to your agency human resources representative.

### SUPPLEMENTAL LIFE ENROLLMENT FOR EXEMPT EMPLOYEES

#### How to Enroll in Supplemental Life

To enroll in supplemental life insurance for exempt employees, visit the Securian Financial website at [lifebenefits.com](http://lifebenefits.com). The initial user ID is "OH" plus your OH|ID Workforce 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 in the Forms section of the Benefits Administration website at [das.ohio.gov/forms](http://das.ohio.gov/forms).

#### FLEXIBLE SPENDING ACCOUNTS ENROLLMENT

The Flexible Spending Accounts Open Enrollment period will be Oct. 19 - 30, 2020. More details to come this fall.



## OPEN ENROLLMENT CHECKLIST

Take the actions below to ensure you are fully prepared for Open Enrollment and to access your benefits throughout the benefit year.

- Decide who you want to cover with your medical insurance. If you currently are enrolled in medical benefits with the State, review your coverage at [myOhio.gov](https://myOhio.gov)>[My Workspace](#)>[My Benefits](#)>[Benefits Summary](#).
- Confirm your medical third-party administrator. Based on the first three digits of your home ZIP code as shown on the chart below, your medical third-party administrator is (check one).
  - Anthem
  - Medical Mutual of Ohio (MMO)

MEDICAL THIRD-PARTY ADMINISTRATOR ZIP CODE AREA	
Third-Party Administrator	ZIP Code Starts With
Anthem	437, 438, 439, 444, 445, 450, 451, 452, 453, 454, 455, 456, 457, 458, and Out of State
Medical Mutual of Ohio	430, 431, 432, 433, 434, 435, 436, 440, 441, 442, 443, 446, 447, 448, and 449

### Medical

- Anthem:
  - [enrollmentanthem.com/stateofohio](https://enrollmentanthem.com/stateofohio)
  - Download Anthem's "Sydney Health" app
- Medical Mutual: <https://stateofohio.medmutual.com>
  - Download the Medical Mutual of Ohio app
- Confirm that your medical and other healthcare providers are in network** – including your physician, dentist, and optometrist
  - Go to the third-party administrator websites to search for your providers
- Determine the medical plan option that best suits the needs of you and your family.** See Pages 8-18 for details, cost comparison charts, and other resources.
  - Ohio Med PPO
  - Ohio Med HDHP with a Health Savings Account (HSA)
- Enroll quickly and easily online
  - Log in to [myOhio.gov](https://myOhio.gov)
  - Enter your OH|ID Workforce User ID and password
  - Click **My Workspace**
  - Under Self Service Quick Access, click **myBenefits**
  - Click Enroll in Benefits**
    - Be prepared to provide proof of newly enrolled dependents to your human resources representative the same day you make your elections
    - For paper enrollment, refer to the details in the Benefits Enrollment Instructions section on Page 6.

### Take Charge | Live Well

- Go to [das.ohio.gov/wellness](https://das.ohio.gov/wellness)
- Log in by creating your personal username and password

### Visit the New Hub

- Access all of your benefits programs via the Hub, [join.virginpulse.com/StateofOhio](https://join.virginpulse.com/StateofOhio)

### Prescription Drug

- OptumRx: [optumrx.com](https://optumrx.com)
  - Prescription Drug coverage is included if you enroll in the Ohio Med plan
  - You can download the OptumRx app
  - Optum Rx cards will be mailed to enrolled members

### For Dental and Vision:

- A printed benefit card is optional and can be requested from the respective vendor below
- Check student status (see the Dental and Vision sections of this guide for details)
- Download the vendor apps

### Dental (for exempt employees)\*

Delta Dental of Ohio: [deltadentaloh.com](https://deltadentaloh.com)

### Vision (for exempt employees)\*

EyeMed Vision Care: [eyemed.com](https://eyemed.com)

### Exempt personnel may choose to enroll in Supplemental Life\*

- Go to Securian Financial at [lifebenefits.com](https://lifebenefits.com). Login instructions: Your initial user ID is "OH" plus your OH|ID Workforce 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 in the Forms section of the Benefits Administration website at [das.ohio.gov/forms](https://das.ohio.gov/forms)

\*Union-represented employees should visit [benefitstrust.org](https://benefitstrust.org) for Open Enrollment details.

- Complete your registration for LiveHealth Online.** Be prepared to connect with a doctor or physician through your mobile device or webcam when the need arises.
  - To complete your registration, log in to [livehealthonline.com](https://livehealthonline.com) or download the LiveHealth Online mobile app.
  - You do not need to be currently enrolled or provide your payment information to register.

### Summary of Benefits and Coverage (SBC)

A requirement of the Patient Protection and Affordable Care Act, the SBC is a concise document that details simple and consistent information about health plan benefits and coverage. It describes the basics of your coverage and allows you to compare any different coverage options. 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/medical](https://das.ohio.gov/medical) and click the SBC bar in the Medical Coverage tab.

## MEDICAL COVERAGE

As an eligible employee enrolling in medical coverage, you automatically gain prescription drug, behavioral health, and Take Charge | Live Well benefits. For eligibility and enrollment details, visit [das.ohio.gov/medical](https://das.ohio.gov/medical).

### Cost

Employees enrolled in the Ohio Med plan through either the Ohio Med PPO or the Ohio Med HDHP pay 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 charts on Page 14 and 15. Out-of-pocket costs are outlined on Page 16.

### 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 Page 9 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

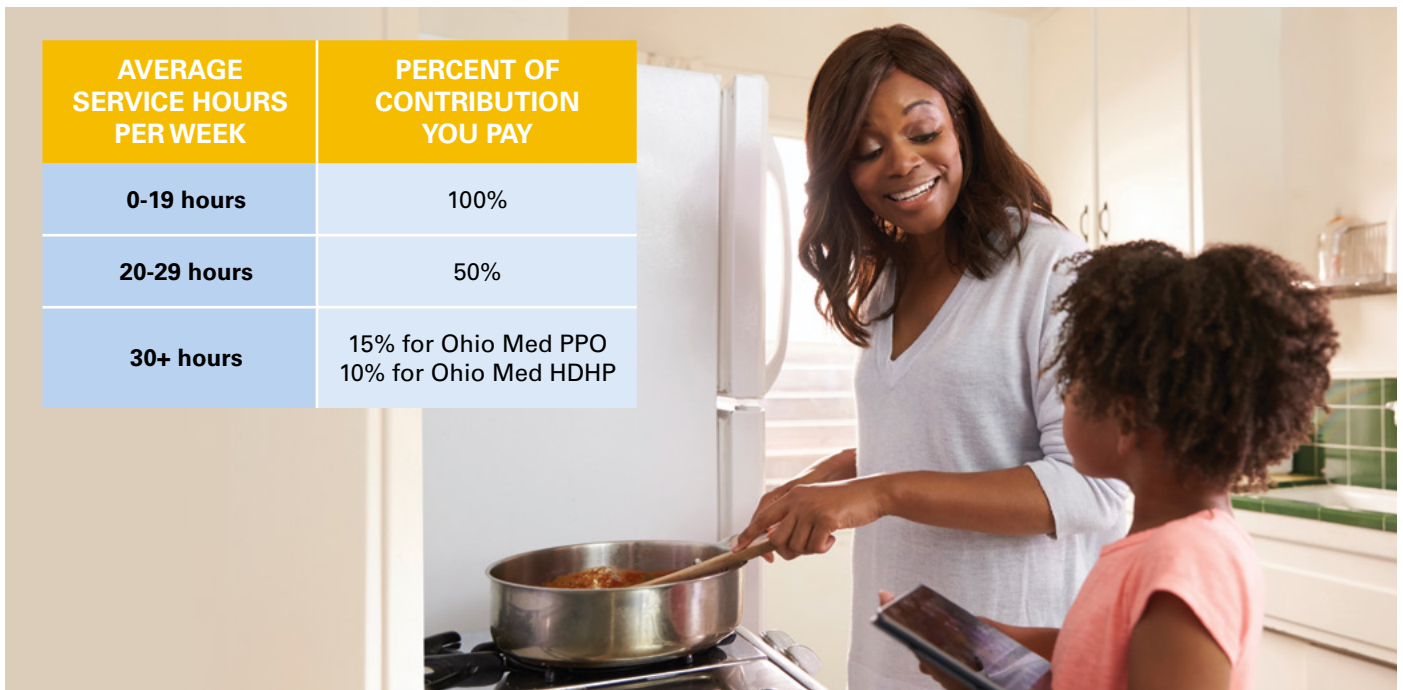
- The contribution tier for part-time permanent employees is determined annually.
- The percentage that part-time permanent employees pay toward their contributions is based on their average number of service hours. Average service hours are calculated over a 12-month period (called the Standard Measurement 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.

### 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.

- Part-time temporary employees are those typically hired as interns, intermittent employees, 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 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.

AVERAGE SERVICE HOURS PER WEEK	PERCENT OF CONTRIBUTION YOU PAY
0-19 hours	100%
20-29 hours	50%
30+ hours	15% for Ohio Med PPO 10% for Ohio Med HDHP





## 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, go to [das.ohio.gov/eligibilityrequirements](https://das.ohio.gov/eligibilityrequirements).

### 1. Spouse

- Your current legal spouse as recognized by Ohio law, who is not already enrolled as a State employee under their own OH|ID Workforce User ID.

### 2. Children younger than age 26 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
- Foster children
- Children for whom either you or your spouse has been appointed legal guardian
- 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 either the Ohio Med PPO or Ohio Med HDHP. 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.

## Specific Benefit Information

The Ohio Med plan does not contain preexisting 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 those in the Ohio Med PPO, which you only pay an office visit copayment.

For specific plan information, see Pages 10-18.

## Enrollment

You can enroll online using myohio.gov. See the Benefits Enrollment Instructions on Page 6.

## DEPENDENT ELIGIBILITY FOR BENEFITS

Dependent Category	Medical	Dental	Vision	Supplemental Life
<b>Children younger than age 23</b>	Coverage available for eligible dependents <sup>1</sup>	Coverage available for eligible dependents <sup>2</sup>	Coverage available for eligible dependents <sup>2</sup>	Coverage available for eligible dependents
<b>Children ages 23 - 25</b>	Coverage available for eligible dependents <sup>1</sup>	No coverage available	No coverage available	Coverage available for eligible dependents

<sup>1</sup> View detailed eligibility and documentation requirements at: [das.ohio.gov/eligibilityrequirements](https://das.ohio.gov/eligibilityrequirements).

<sup>2</sup> Student verification is needed for dependents age 19 to age 23. View detailed eligibility and documentation requirements at: [das.ohio.gov/eligibilityrequirements](https://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.**

## ONE MEDICAL PLAN\*: OHIO MED TWO PLAN DESIGNS: OHIO MED PPO AND OHIO MED HDHP

What is covered in each plan design is similar. What is different is how the plan is administered as well as costs.

### What is a Preferred Provider Organization?

A Preferred Provider Organization (PPO) is a medical plan that offers benefits at both in-network and out-of-network levels with set copay amounts for certain services. When you enroll in the Ohio Med PPO, you may visit any doctor and receive benefits. However, the coverage amount is greater when you use in-network providers.

### What is a High Deductible Health Plan?

A High Deductible Health Plan (HDHP) is a medical plan that offers benefits at both in-network and out-of-network levels with a higher deductible and out-of-pocket maximum than the PPO plan. The contribution is usually lower, but you pay more health care costs before the medical third-party administrator starts to pay its share. The HDHP comes with a Health Savings Account (HSA), which allows you to pay for certain medical expenses with money free from federal taxes. For more information on the HSA, see Page 12.

Employees enrolled in the Limited Purpose FSA can still enroll in the Ohio Med HDHP.

**Exclusions from the HDHP:** If you or your spouse are currently enrolled in a Flexible Spending Account – Health Care Spending Account for calendar year 2020, neither of you are eligible to enroll in the Ohio Med HDHP. This also applies if you have a carryover balance as of Dec. 31. You also cannot enroll in the HDHP if you are currently enrolled in Medicare or Tricare. You may enroll or remain enrolled in the Ohio Med PPO.

### Ohio Med PPO

- This plan is a Preferred Provider Organization (PPO)
- Has a higher employee contribution, but a lower deductible
- Copay amounts are set for medical services such as a visit to the doctor or hospital, and prescriptions
- Prescription costs are not combined with medical to meet your out-of-pocket maximum
- There is a separate \$3,500 single or \$7,000 family out-of-pocket maximum that must be met before prescription costs may be paid at 100%
- Each person covered in a family plan must meet the individual deductible or the combined family deductible, whichever occurs first, before the plan begins to pay

### Ohio Med HDHP

- The high deductible health plan (HDHP) includes a Health Savings Account (HSA) with a State contribution to your account (see Page 12 for details)
- Has a lower employee contribution, but a higher deductible
- Initial expenses can be paid by you using the HSA, or you could be reimbursed after a claim has been submitted
- Neither you nor your spouse can currently be enrolled in or have a carryover balance from the previous calendar year in any Flexible Spending Account – Health Care Spending Account
- You can enroll in a Limited Purpose Flexible Spending Account
- Prescription costs are combined with medical to meet your out-of-pocket maximum
- If you are in a family plan, the plan will begin to pay only after the entire family deductible has been met

*\* Your medical third-party administrator is determined by your home ZIP code (either Anthem or Medical Mutual of Ohio). See the Third-Party Administrator ZIP Code Zone Chart on Page 7.*

### Which Plan is Best for You and Your Family?

**Ohio Med PPO** could be the best option if you:

- Prefer to know in advance the cost of your copayments, including doctor visits, prescriptions, hospital stays, and medical services
- Anticipate a high-cost medical expense, such as surgery
- Have a chronic condition or a need for frequent doctor visits
- Take a high-cost specialty drug or take multiple prescriptions

**Ohio Med HDHP** could be the best option if you:

- Prefer to actively manage your health care spending by regularly comparing costs and saving for future medical expenses
- Rarely need doctor visits
- Have the ability to pay, up front, the full deductible and out-of-pocket costs for medical expenses at the time that you incur these costs
- Are able to contribute to your Health Savings Account and prefer to save for future medical expenses including expenses after you retire

*Source: Medical Mutual of Ohio*

## IMPORTANT POINTS ABOUT THE HDHP

The deductible must be reached first before the plan pays toward any of your medical, pharmacy, or behavioral health costs. If you have family coverage, the plan will begin to pay only after the entire family deductible has been met. This is especially important to understand if a major medical expense or a high-cost specialty drug needs to be covered within the first few days, weeks, or months of the Ohio Med HDHP plan taking effect.

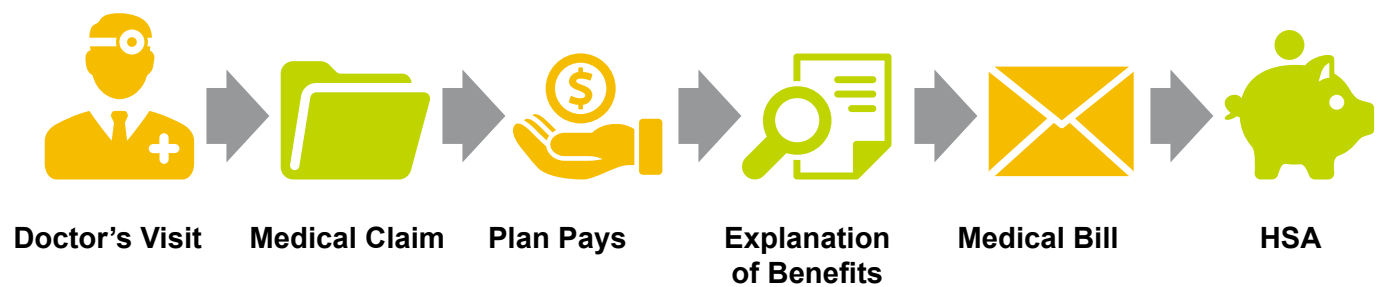
For example, if your medical coverage would begin on August 1 and an accident would occur on August 4, you should ensure that you can pay the full out-of-pocket cost (including the deductible) for the plan option that you selected: either single coverage at \$3,500 or family coverage at \$7,000. After you meet your deductible, the plan would cover expenses at 80%. After the full amount of the out-of-pocket maximum is paid, the plan would cover expenses at 100%.

Specialty drugs could have a high cost (even into the thousands of dollars). If you or a dependent already are taking, or could be taking, a specialty drug, use a cost comparison tool at [optumbank.com/myohiohsa](http://optumbank.com/myohiohsa) to determine which is the best medical plan for you. Your deductible is used to pay for the specialty drug before the plan will pay.

Enrollment in the HDHP is online only. Because the federal guideline for the HSA requires a personal bank account (provided by Optum Bank) managed by you, and because contributions to the HSA are determined by you, enrollment in the Ohio Med HDHP only can be completed online through [myOhio.gov](http://myOhio.gov).

For eligibility details, visit [das.ohio.gov/eligibilityrequirements](http://das.ohio.gov/eligibilityrequirements).

## HOW HDHP CLAIMS ARE PAID



You go to the doctor.

The doctor sends a claim to your medical third-party administrator with a list of services you received. The claim is reviewed and processed based on your plan benefits.

Your medical third-party administrator lets the doctor know how much is being paid for covered medical services and how much, if anything, you have to pay.

Your medical third-party administrator sends an explanation of benefits to you. It's not a bill; it's a summary of how the claim was processed and what, if anything, you owe the doctor.

If you owe the doctor any money, the doctor will bill you for it and you can pay the doctor directly.

You can use any available funds in your HSA to pay the doctor if you have money in your HSA.





## SAVE SMART WITH A HEALTH SAVINGS ACCOUNT

The Health Savings Account (HSA) is an account that is funded by employer and employee contributions on a pre-tax basis to help pay for eligible medical expenses, including deductibles and coinsurance. The HSA is only available as part of the Ohio Med HDHP option and automatically comes with the HDHP; the two cannot be separated.

An HSA is set up online through Optum Bank ([optumbank.com](http://optumbank.com)), similar to a bank account at a brick and mortar bank. An HSA is your personal bank account and allows you to manage your funds.

- HSA funds are yours to keep
- There is no “use it or lose it” rule at the end of the year
- HSA funds stay with you even if you change jobs, leave employment with the State of Ohio, or retire
- After reaching an investment threshold of \$2,100, you can:
  - Invest in the mutual funds offered from Optum Bank
  - Move investments from various funds
  - Transfer money between your HSA and your investment account

Through Optum Bank, [optumbank.com](http://optumbank.com), employees enrolled in the Ohio Med HDHP will be able to access their HSA as well as utilize the following:

- HSA Calculators
- A Health Savings Checkup tool
- A health account comparison tool
- Videos and webinars

### HSA Employer Contribution

From Jan. 1, through Dec. 31, 2020, the HSA contribution limit for individual coverage is \$3,550, and the limit for family coverage is \$7,100. **If you are 55 years of age or older, you may make a catch-up contribution of \$1,000.** When enrolled in the HDHP, your monthly premium will be lower. You can use these savings to contribute to the HSA.

### HSA Employer Contribution

To help get your HSA started, the State of Ohio will make contributions to your HSA if you select the Ohio Med HDHP option. The employer contribution is prorated for new hires. If you are eligible for, and enroll in, the Ohio Med HDHP option, you will receive the employer contribution for each year you are enrolled. The employer contribution counts toward your annual maximum. For new hires, the first contribution may be prorated based on the date of hire.

### HSA EMPLOYER CONTRIBUTION SCHEDULE

2020-21 Plan Year	Single/Family
July 2020	\$500/\$1,000 (Prorated for new hires)
January 2021	\$500/\$1,000 (Prorated for new hires)

### 3 Ways to Receive Tax Savings

#### Typically, you:

- Won't pay tax on money deposited in the HSA (although the IRS limits how much can be contributed each year)
- Won't pay tax on qualified medical expenses, including dental and vision expenses
- Grow your savings tax-free, which can be used for expenses now or in retirement

### Easy Access to Your Account

Through the Optum Bank mobile app or website, you can:

- Track balances and transactions
- Make an HSA contribution
- Capture and submit receipts
- Learn how to maximize your HSA

For more information, go to [optumbank.com/myohiohsa](http://optumbank.com/myohiohsa).

## COMPARING MEDICAL PLAN OPTIONS

		OHIO MED PPO		OHIO MED HDHP	
		Providers In Network	Providers Out of Network	Providers In Network	Providers Out of Network
<b>Deductible</b>	Single	\$400	\$800	\$2,000	\$4,000
	Family	\$800	\$1,600	\$4,000	\$8,000
<b>Office Visits</b>	Doctor	\$30	\$50	Deductible/ 20% Coinsurance	Deductible/ 40% Coinsurance
	Specialist	\$35	\$55	Deductible/ 20% Coinsurance	Deductible/ 40% Coinsurance
<b>Out-of-pocket Maximum</b>	Single	\$2,500 Medical/ Behavioral Health Combined	\$5,000 Medical/ Behavioral Health Combined	\$3,500 Medical/ Behavioral Health/ Pharmacy Combined	\$7,000 Medical/Pharmacy/ Behavioral Health Combined
	Family	\$5,000 Medical/ Behavioral Health Combined	\$10,000 Medical/ Behavioral Health Combined	\$7,000 Medical/ Behavioral Health/ Pharmacy Combined	\$14,000 Medical/Pharmacy/ Behavioral Health Combined
<b>Prescription Drugs</b>	Retail (30-day supply)	\$10 / \$40 / \$75 (See chart on Page 22)	N/A	Deductible/ 20% Coinsurance	N/A
	Home Delivery (90-day supply)	\$25 / \$100 / \$187.50 (See chart on Page 22)	N/A	Deductible/ 20% Coinsurance	N/A
	Pharmacy Out-of-pocket Limit	\$3,500/\$7,000	N/A	Included in Medical	Included in Medical

## MEDICAL CARE COMPARISON – WHERE TO GO FOR CARE

	OHIO MED PPO	OHIO MED HDHP	<b>Average Cost</b>
	<b>Doctors in your plan</b>	<b>Doctors in your plan</b>	
<b>Preventive Care</b>	100%	100%	
<b>Telehealth</b>	\$10	Deductible/Coinsurance	\$59
<b>Doctor Visits</b>	\$30	Deductible/Coinsurance	\$127
<b>Specialist Visits</b>	\$35	Deductible/Coinsurance	\$152
<b>Retail Health Clinics</b>	\$30	Deductible/Coinsurance	\$55
<b>Urgent Care Clinic</b>	\$40	Deductible/Coinsurance	\$107
<b>Free Standing or Hospital Emergency Room</b>	\$150 / 80%	Deductible/Coinsurance	\$1,540

## OHIO MED PPO CONTRIBUTIONS: EMPLOYEE / EMPLOYER SHARE

OHIO MED PPO CONTRIBUTIONS						
FULL-TIME EMPLOYEE CONTRIBUTIONS						
BIWEEKLY PAID EMPLOYEE CONTRIBUTIONS <sup>1</sup> 15% TIER  FULL-TIME PERMANENT PART-TIME PERMANENT (30 OR MORE HOURS A WEEK) PART-TIME TEMPORARY (30 OR MORE HOURS A WEEK)				MONTHLY PAID EMPLOYEE CONTRIBUTIONS <sup>1</sup> 15% TIER  FULL-TIME EMPLOYEES		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	\$53.34	\$301.17	\$354.51	\$115.57	\$652.54	\$768.11
Family Minus Spouse	\$146.08	\$826.69	\$972.77	\$316.49	\$1,791.13	\$2,107.62
Family Plus Spouse <sup>2</sup>	\$155.31	\$826.69	\$982.00	\$336.49	\$1,791.13	\$2,127.62
PART-TIME EMPLOYEE CONTRIBUTIONS						
BIWEEKLY PAID EMPLOYEE CONTRIBUTIONS <sup>1</sup> 50% TIER  PART-TIME PERMANENT (20.00 - 29.99 HOURS A WEEK)				BIWEEKLY PAID EMPLOYEE CONTRIBUTIONS <sup>1</sup> 100% TIER  PART-TIME PERMANENT EMPLOYEES (UPTO 19.99 HOURS A WEEK)		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	\$177.25	\$177.26	\$354.51	\$354.51	\$0.00	\$354.51
Family Minus Spouse	\$486.38	\$486.39	\$972.77	\$972.77	\$0.00	\$972.77
Family Plus Spouse <sup>2</sup>	\$495.61	\$486.39	\$982.00	\$982.00	\$0.00	\$982.00
<p><sup>1</sup> These rates represent the total amount that will be contributed from your paycheck.</p> <p><sup>2</sup> Family Plus Spouse rates above include a charge of \$20 per month to cover a spouse. For those who receive paychecks biweekly, the Family Plus Spouse rates above include a charge of \$9.23 per pay to cover a spouse.</p>						

## OHIO MED HDHP CONTRIBUTIONS: EMPLOYEE / EMPLOYER SHARE

OHIO MED HDHP CONTRIBUTIONS						
FULL-TIME EMPLOYEE CONTRIBUTIONS						
BIWEEKLY PAID EMPLOYEE CONTRIBUTIONS <sup>1</sup> 10% TIER  FULL-TIME PERMANENT PART-TIME PERMANENT (30 OR MORE HOURS A WEEK) PART-TIME TEMPORARY (30 OR MORE HOURS A WEEK)				MONTHLY PAID EMPLOYEE CONTRIBUTIONS <sup>1</sup> 10% TIER  FULL-TIME EMPLOYEES		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	\$35.75	\$319.92	\$355.67	\$77.46	\$693.16	\$770.62
Single Plus Spouse	\$80.15	\$719.53	\$799.68	\$173.66	\$1,558.98	\$1,732.64
Family Minus Spouse	\$62.39	\$559.69	\$622.08	\$135.18	\$1,212.65	\$1,347.83
Family Plus Spouse	\$106.79	\$959.29	\$1,066.08	\$231.38	\$2,078.47	\$2,309.85
PART-TIME EMPLOYEE CONTRIBUTIONS						
BIWEEKLY PAID EMPLOYEE CONTRIBUTIONS <sup>1</sup> 50% TIER  PART-TIME PERMANENT (20.00 - 29.99 HOURS A WEEK)				BIWEEKLY PAID EMPLOYEE CONTRIBUTIONS <sup>1</sup> 100% TIER  PART-TIME PERMANENT EMPLOYEES (UPTO 19.99 HOURS A WEEK)		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	\$177.83	\$177.84	\$355.67	\$355.67	\$0.00	\$355.67
Single Plus Spouse	\$399.84	\$399.84	\$799.68	\$799.68	\$0.00	\$799.68
Family Minus Spouse	\$311.04	\$311.04	\$622.08	\$622.08	\$0.00	\$622.08
Family Plus Spouse	\$533.04	\$533.04	\$1,066.08	\$1,066.08	\$0.00	\$1,066.08

<sup>1</sup> These rates represent the total amount that will be contributed from your paycheck.

**Board and commission members** who submit direct payments to their agency human resources representative for their medical contributions cannot contribute to the HSA through payroll. For questions, contact your agency human resources representative.

## IN-NETWORK AND OUT-OF-NETWORK COSTS FOR MEDICAL PLANS

IN-NETWORK AND OUT-OF-NETWORK COSTS		
	Ohio Med PPO	Ohio Med HDHP
<b>Annual Deductible</b>	\$400 single, \$800 family in-network; \$800 single, \$1,600 family out-of-network.	\$2,000 single/\$4,000 family in-network \$4,000 single/\$8,000 family out-of-network
<b>Your Copayments (Office Visits)</b>	Primary care physician: \$30 in-network, \$50 out-of-network; Specialist: \$35 in-network; \$55 out-of-network. Outpatient office visit, intensive outpatient care: \$20 in network; \$30 out-of-network (balance billing applies).	80% after deductible in-network 60% after deductible out-of-network
<b>Coinsurance</b>	<b>Medical:</b> You pay 20%, plan pays 80% in-network; you pay 40%, plan pays 60% out-of-network. <b>Behavioral Health:</b> Outpatient in-network: 100% after office visit copay; 80% of other services; <ul style="list-style-type: none"> <li>Outpatient out-of-network: 60% of contracted allowable amount after copayment (balance billing applies)</li> <li>Inpatient in-network: 80% after deductible</li> <li>Inpatient out-of-network: 60% after deductible, \$350 penalty if not preauthorized</li> </ul>	80% after deductible in-network 60% after deductible out-of-network
<b>Your Out-of-Pocket Maximum</b>	\$2,500 single, \$5,000 family in-network; \$5,000 single, \$10,000 family out-of-network. This deductible is combined with behavioral health.	\$3,500 single/\$7,000 family in-network \$7,000 single/\$14,000 family out-of-network
<b>Behavioral Health</b>	No day, annual or lifetime limits. Some benefit limits may apply: for details, visit <a href="https://das.ohio.gov/behavioralhealth">das.ohio.gov/behavioralhealth</a> , click the Summary Plan Descriptions tab and select the current summary plan.	Same as PPO

### BENEFIT/SERVICE COVERAGE LEVELS

<b>Chiropractic Care</b>	<ul style="list-style-type: none"> <li>Covered at 80% in-network; 60% out-of-network</li> <li>Unlimited visits (review required after 25 visits)</li> </ul>	80% after deductible in-network 60% after deductible out-of-network
<b>Diagnostic, X-Ray and Lab Services</b>	<ul style="list-style-type: none"> <li>Covered at 80% in-network; 60% out-of-network</li> </ul>	80% after deductible in-network 60% after deductible out-of-network
<b>Durable Medical Equipment</b>	<ul style="list-style-type: none"> <li>Covered at 80% in-network; 60% out-of-network</li> </ul>	80% after deductible in-network 60% after deductible out-of-network
<b>Emergency Room</b>	<ul style="list-style-type: none"> <li>Covered at 80%; \$150 copay, which is waived if patient is admitted as inpatient; 60% out-of-network for non-emergency</li> </ul>	80% after deductible; 60% after deductible out-of-network for non-emergency
<b>Immunizations</b>	<ul style="list-style-type: none"> <li>Most are covered at 100% in-network; 60% out-of-network</li> </ul>	Same as PPO
<b>Maternity – Delivery</b>	<ul style="list-style-type: none"> <li>Covered at 80% in-network; 60% out-of-network</li> </ul>	80% after deductible in-network 60% after deductible out-of-network
<b>Physical, Occupational, and Speech Therapy</b>	<ul style="list-style-type: none"> <li>Covered at 80% in-network; 60% out-of-network</li> <li>Unlimited visits (review required after 25 visits)</li> <li>Includes coverage for Autism Spectrum Disorder</li> </ul>	80% after deductible in-network 60% after deductible out-of-network
<b>Preventive Exams and Screenings</b>	<ul style="list-style-type: none"> <li>Most preventive care covered at 100% in-network; 60% out-of-network</li> <li>Age restrictions may apply</li> </ul>	Same as PPO
<b>Urgent Care</b>	<ul style="list-style-type: none"> <li>\$40 copay in-network; \$60 copay out-of-network</li> <li>Covered at 80% in-network; 60% out-of-network</li> </ul>	80% after deductible in-network 60% after deductible out-of-network

Non-network services: Plan pays 60% of Ohio Med PPO and Ohio Med HDHP contracted allowable amount and you pay any remaining balance (subject to balance billing).

If your out-of-network charge is greater than the contracted allowable amount, your out-of-pocket costs will be more.

For a list of immunizations paid at 100%, see Page 17.



## 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.

The Ohio Med PPO and Ohio Med HDHP offer 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		FREE IMMUNIZATIONS	
<b>Clinical breast exam</b>	1/plan year	<b>Diphtheria, tetanus, pertussis (DTap)</b>	2/4/6/15-18 months; 4-6 years
<b>Colonoscopy</b>	Every 10 years starting at age 50	<b>Haemophilus influenza b (Hib)</b>	2/4/6/12-15 months
<b>Flexible sigmoidoscopy</b>	Every 10 years starting at age 50	<b>Hepatitis A (HepA)</b>	2 doses between 1-2 years
<b>Glucose</b>	1/plan year	<b>Hepatitis B (HepB)</b>	Birth; 1-2 months; 6-18 months
<b>Gynecological exam</b>	1/plan year	<b>Human Papillomavirus (HPV)</b>	3 doses for 9-26 years
<b>Hemoglobin, hematocrit or CBC</b>	1/plan year	<b>Influenza</b>	1/plan year
<b>Lipid profile or total and HDL cholesterol</b>	1/plan year	<b>Measles, mumps, rubella (MMR)</b>	12-15 months, then at 4-6 years; adults who lack immunity
<b>Mammogram</b>	1 routine and 1 medically necessary/plan year	<b>Meningococcal (MCV4)</b>	1 dose between 11-12 years or start of high school or college
<b>Pre-natal office visits</b>	As needed; based on physician's ability to code claims separately from other maternity-related services	<b>Pneumococcal</b>	2/4/6 months; 12-15 months; annually at age 65 and older; high risk groups
<b>Stool for occult blood</b>	1/plan year	<b>Poliovirus (IPEV)</b>	2 and 4 months; 6-18 months; 4-6 years
<b>Urinalysis</b>	1/plan year	<b>Rotavirus (Rota)</b>	2/4/6 months
<b>Well-baby, well-child exam</b>	Various for birth to 2 years; then annual to age 21	<b>Tetanus, diphtheria, pertussis (Td/Tdap)</b>	11-12 years; Td booster every 10 years, 18 and older
<b>Well-person exam (annual physical)</b>	1/plan year	<b>Varicella (Chickenpox)</b>	12-15 months; 4-6 years; 2 doses for susceptible adults
		<b>Zoster (shingles)</b>	1 dose for age 19 and older 2 doses for Shingrix

## TELEHEALTH – LIVEHEALTH ONLINE

### Get the Medical Treatment and Advice You Need Quicker for Minimal Cost

*Don't have time to go to the doctor? Bring the doctor to you with LiveHealth Online.*

Visit with a doctor 24/7 using the new telehealth service.

*Feeling under the weather? Don't want to fight traffic to get to the doctor? Searching for care after hours? Without leaving your home, LiveHealth Online allows you to:*

- Visit with a doctor through live video chat 24/7
- Select your choice of U.S. board-certified doctors from among those available at the time of service

**Chat with a board-certified doctor.** The doctor can assess your condition, recommend a treatment plan, and even prescribe basic medications (not narcotics or controlled substances) for pickup at a nearby pharmacy.

Visit with a licensed therapist or board-certified psychiatrist. When stress, anxiety, or depression occurs, talking with a therapist online may be the most convenient solution. In most cases, an appointment can be made to talk with a therapist in four days or less.

### 24-HOUR NURSE LINES

For non-life-threatening health-related questions, employees enrolled in the State's medical plan (either Ohio Med PPO or Ohio Med HDHP) may contact the 24-Hour Nurse Line provided by your medical third-party administrator.

**Anthem: 800-337-4770**

**Medical Mutual of Ohio: 888-912-0636**

Calling the free nurse line can help you obtain the answers to your health-related questions wherever you are, whenever you need it.

**Save time and money.** Download the free LiveHealth Online app on your mobile device to get the care you need by chatting with a doctor online for the following conditions and more:

- Flu
- Allergies
- Headache
- Cold
- Fever
- Sore throat
- Tooth pain
- Minor rash
- Skin infection
- Pink eye

With just a \$10 copay for the Ohio Med PPO or \$59 for the Ohio Med HDHP, LiveHealth Online costs much less than a trip to an emergency room, an urgent care center, or even a walk-in clinic. Prices vary for behavioral health visits for HDHP members. (\$80 for a therapist, \$95 for a psychologist, \$175 for an initial visit with a psychiatrist and \$75 for follow-up visits.)

### LiveHealth Online Registration

Employees enrolled in the State of Ohio medical plan have been pre-registered in LiveHealth Online. go to the LiveHealth Online website, [livehealthonline.com](https://livehealthonline.com), or the mobile app.

For life-threatening health situations, call 9-1-1 or go to an emergency room for immediate assessment and treatment.



## COST-SAVING TOOLS

### Be a Better Health Care Consumer

Being a smart consumer and making informed choices is one way to keep your cost and the State's cost of medical claims down. You can start by choosing a primary care physician and keeping regular visits. Developing a relationship with your physician can reduce trips to the emergency room or urgent care facility. Taking advantage of preventive care coverage is another way to stay healthy.

**Recommended:** To determine which plan design best fits your needs, use the cost comparison tools from your medical third-party administrator (Anthem or Medical Mutual of Ohio) to determine your annual health care spending needs and trends. For the cost comparison tools provided by Anthem and Medical Mutual of Ohio, see the Did You Know section to the right.

### Shopping for the Right Care:

#### How to Save Money and Ensure Quality Standards

FINDING THE RIGHT CARE		
Options	What It Is	Best For
24-Hour Nurse Lines (Free)	Talk with a nurse Anthem: 800-337-4770 Medical Mutual: 888-912-0636	Non-life-threatening health-related questions or concerns
Telehealth Services \$	Visiting with a doctor, therapist, or psychiatrist via a smartphone, tablet, or computer with a webcam using LiveHealth Online	Getting care 24/7 easily and conveniently for cold/flu, sinus infections, coughs, sore throats, and behavioral health services
Doctor's Office \$\$	Visiting your primary care physician or a physician within your third-party administrator's network	Check-ups, physicals, infections, minor sprains, sore/strep throat, coughs, cold/flu, vaccines
Walk-in Clinic \$\$	Clinic in retail store or pharmacy staffed by nurse practitioners	Basic care: Ear/sinus infections, sore/strep throat, minor sprains, bronchitis, coughs, cold/flu, vaccines
Urgent Care Center \$\$\$	Self-standing center or located in health facility; staffed by physicians and nurses	Serious, non-life-threatening care: Fractures or sprains needing X-rays, deep cuts needing stitches, severe rashes
Emergency Room \$\$\$\$	Free-standing or hospital department open 24/7; staffed and equipped for life-threatening care	Threats to life or limb: Chest pain, difficulty breathing, seizures, major fracture, head trauma, bleeding, allergic reaction, loss of consciousness

### DID YOU KNOW...

Providers in your network may charge significantly different rates for the same procedure. Similar to searching for a new car, to find the best price, it's best to do comparison shopping.

Whether you're needing lab work, X-rays, or a medical procedure, researching the costs at different providers could help you save money.

To best manage your health care spend, go to your third-party administrator's website and use the cost comparison tool:

#### Anthem:

[enrollmentanthem.com/stateofohio](http://enrollmentanthem.com/stateofohio)

#### Medical Mutual of Ohio:

[stateofohio.medmutual.com](http://stateofohio.medmutual.com)

## WHERE TO GET CARE

### Right Care. Right Place. Right Time

#### Non-Emergency

- Anthem: 800-337-4770
- Medical Mutual: 888-912-0636

#### 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
- Contact LiveHealth Online via the app or your webcam

## 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](http://hospitalsafetygrade.org)
- Hospital Compare
  - Summarizes up to 64 quality measures
  - [medicare.gov/hospitalcompare](http://medicare.gov/hospitalcompare)

Source: Health Action Council

## 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

## 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, 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.



### STAY CONNECTED 24/7 WITH THESE APPS

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

- Anthem: Sydney Health
- Medical Mutual of Ohio
- LiveHealth Online (Telehealth)
- OptumRx (Prescription Drug)
- Virgin Pulse (Take Charge | Live Well)
- Optum: myLiveandworkwell (Behavioral Health)
- Delta Dental
- EyeMed Vision Care
- WageWorks



## PRESCRIPTION DRUG BENEFITS

Included with your selected medical plan, OptumRx provides prescription drug benefits for State of Ohio employees and their enrolled dependents.

### 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 22.

### Eligibility

Employees and dependents enrolled in the Ohio Med PPO or Ohio Med HDHP 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. Specific test values and results are not required, only that the member has had the test. Members enrolled in the Ohio Med HDHP are not eligible for free diabetic supplies.

#### Specialty Drug Management Program

Some specialized medications for serious medical conditions such as cancer, cystic fibrosis, and rheumatoid

arthritis must be obtained from Optum Specialty, 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](https://das.ohio.gov/prescriptiondrug) under the Specialty Drug List.

### Not All Drugs are Covered

Some drugs are not covered at all, and some 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](https://das.ohio.gov/prescriptiondrug), under “Prescription Drug Updates.”



### OptumRx Website Offers Price and Save, Tracking Tools

All of your pharmacy plan information is available at your fingertips 24/7 and can be accessed on the OptumRx private, secure website at [optumrx.com](http://optumrx.com). 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
- Learn more about your prescription drugs

### Enrollment

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



## PRESCRIPTION COSTS

TYPE OF MEDICATION	OHIO MED PPO COPAYMENT COSTS				OHIO MED HDHP COINSURANCE COSTS
	30-DAY SUPPLY AT RETAIL COPAYMENT	30-DAY SUPPLY SPECIALTY COPAYMENT	90-DAY SUPPLY AT RETAIL COPAYMENT	90-DAY SUPPLY AT MAIL-ORDER COPAYMENT	ALL TYPES OF MEDICATION
<b>Generic</b>	\$10	\$10	\$30	\$25	You pay 100% until the deductible is met, then 20% until the out-of-pocket limit is met.  Deductible amounts: \$2,000 single/ \$4,000 family
<b>Preferred Brand-Name</b>	\$40	\$40	\$120	\$100	
<b>Non-Preferred Brand-Name, Generic Unavailable</b>	\$75	\$75	\$225	\$187.50	
<b>Non-Preferred Brand-Name, Generic Available</b>	\$75 plus the difference between the cost of the brand-name and generic drug	\$75 plus the difference between the cost of the brand-name and generic drug	\$225 plus the difference between the cost of the brand-name and generic drug	\$187.50 plus the difference between the cost of the brand-name and generic drug	
<b>Out-of-Pocket Maximum*</b>	\$3,500 single/\$7,000 family				
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 <a href="http://das.ohio.gov/prescriptiondrug">das.ohio.gov/prescriptiondrug</a> .  * Pharmacy copays do not apply toward the medical/behavioral health plan deductibles and the annual out-of-pocket maximum for the Ohio Med PPO.					

## BEHAVIORAL HEALTH BENEFITS

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

### 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 on Page 16.

### Eligibility

Employees and dependents enrolled in the Ohio Med PPO or Ohio Med HDHP 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
- Physical abuse

### Support for dependents battling substance use

The State's health plan offers Optum's Family Support Program to help care for eligible dependents who have a substance use problem or a mental health concern. 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
- 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](https://liveandworkwell.com), and enter the access code: 00832.

Identifying substance use disorders can be confusing. For substance use support and to speak with a licensed



clinician, contact Optum's Substance Use Disorder Helpline at 1-855-780-5955 24 hours a day or visit [liveandworkwell.com/recovery](https://liveandworkwell.com/recovery).

### Enrollment

You automatically gain coverage in behavioral health benefits when you are enrolled in medical coverage. Your medical coverage ID card (Anthem or Medical Mutual of Ohio) is the only proof of insurance that you need to present for behavioral health services. Medical coverage ID cards or Optum Behavioral Health cards can be used as proof of insurance.

## OHIO EMPLOYEE ASSISTANCE PROGRAM

### Cost

As a State of Ohio employee, there is no cost to you for the Ohio Employee Assistance Program (Ohio EAP). 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 Ohio EAP services. You do not need to be enrolled in the Ohio Med PPO or the Ohio Med HDHP for these services.

### Specific Benefit Information

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

Visit [ohio.gov/eap](https://ohio.gov/eap) for more information about Ohio EAP services.

### Enrollment

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



## WELLNESS PROGRAM

### NEW BRAND, ADMINISTRATOR, AND REWARDS PROGRAM

Take Charge | Live Well – the State’s wellness program for employees and spouses enrolled in the State of Ohio Medical plan – will be managed by Virgin Pulse beginning July 1, 2020. Virgin Pulse is an industry leader in corporate wellness programs.

#### Cost

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

#### Eligibility

Employees and spouses enrolled in either the Ohio Med PPO or Ohio Med HDHP automatically receive benefits for the Take Charge | Live Well program.

#### Specific Benefit Information

Take Charge | Live Well will help you make small, everyday changes to your well-being that are focused on the areas you want to improve the most. When you stick to our program, you’ll build healthy habits, have fun with co-workers, and experience the lifelong rewards of better health and well-being.

#### Wellness Program Benefits

The Hub: Employees and spouses enrolled in the medical plan, which includes the Take Charge | Live Well program, will have a centralized Hub to access via a web portal or smart device. The Hub, hosted by Virgin Pulse, will serve as the central point of contact for all benefit services within four pillars of well-being:

- Physical
- Emotional
- Social
- Financial

#### Participation-Based Incentives

Enrolled employees and spouses can earn up to \$350 per person for completing activities through the Virgin Pulse Hub.



#### PARTICIPATION-BASED INCENTIVES

Members can earn \$350 per individual or \$700 per family

<b>Health Risk Assessment</b>	<b>\$50</b> for completion
<b>Biometric Screening</b>	<b>\$100</b> for completion
<ul style="list-style-type: none"> <li>• On-site biometric screening</li> <li>• Submission of Physician Form</li> </ul>	
<b>Tobacco Cessation</b>	<b>\$100</b> after completion of four coaching calls
<b>Wellbeats</b>	<b>\$50</b> for every 10 classes completed
More than 400 fitness and nutrition classes offered 24/7 with smartphone app	
<b>Coaching Calls</b>	<b>\$25</b> per once-monthly coaching call
<b>Preventative Screenings and Immunizations</b>	<b>\$25</b> per visit or vaccine administered
<b>Wellness Challenges</b>	<b>\$25</b> per Virgin Pulse Corporate Challenge, offered three times per program year
<b>Community Events</b>	<b>\$10</b> per activity via Attestation Form
<ul style="list-style-type: none"> <li>• Regional fitness activities: marathon, 5K event, charity events (such as Pelotonia), fitness competition or event</li> <li>• Charitable or volunteer activities: Combined Charitable Campaign, American Red Cross blood drive</li> <li>• Regional community events</li> </ul>	
<b>Financial Well-Being</b>	<b>\$10</b> per activity via Attestation Form
<ul style="list-style-type: none"> <li>• Ohio Public Employees Retirement System (OPERS), Deferred Compensation or other retirement planning webinar or course</li> <li>• Credit Union of Ohio educational training</li> <li>• Opening of a new account via the Credit Union of Ohio or Deferred Compensation</li> <li>• Contribution to an Health Savings Account (HSA)</li> <li>• Completion of financial educational course(s)</li> </ul>	
<b>Wellness Events</b>	<b>\$10</b> per event completed via Attestation Form
<ul style="list-style-type: none"> <li>• Agency-sponsored health fairs, webinars or agency health initiatives</li> <li>• State-sponsored health and wellness activities</li> <li>• Prenatal, infant and maternity classes</li> <li>• Utilization of Ohio Employee Assistance Program or Optum Behavioral Health Services</li> <li>• Webinars offered by Virgin Pulse</li> </ul>	



## OUTCOME-BASED INCENTIVES

Enrolled employees and spouses will also have the opportunity to **earn an additional \$200 per person** in outcome-based incentives by maintaining a body mass index (BMI), reducing their BMI, or completing a “reasonable alternative,” if applicable, each program year.

- Attain a body mass index (BMI) between 18.5-29.9
- Members with a BMI over 29.9 can work to reduce their BMI by utilizing the Virgin Pulse platform offerings, programs, and resources
- Members unable to reduce their BMI to the targeted marker can either:
  - Achieve a 5% weight reduction from the prior year, or
  - Complete a reasonable alternate standard via the Virgin Pulse-supported program to attain the outcome-based incentive

### Virgin Pulse Tools and Resources

Beginning July 1, 2020, members will continue to receive helpful services such as phone coaching and wellness challenges to support you in your quest for better health. Through Virgin Pulse, Take Charge | Live Well offers the following tools and resources to help you be your healthy best.

**Wellbeats** – Virtual fitness app offering more than 400 fitness classes and nutrition courses.



**Nutrition Guide** – Choose what you’d like to work on, like cutting out sweets or portion control. Then get tips to help you achieve your goals.

**Sleep Guide** – What’s your sleep like? Decide what you need to work on, like getting to bed earlier or quieting down. Then get information to help you rest.

**Diabetes Prevention Program** – Members identified as pre-diabetic can access the Centers for Disease Control’s certified Diabetes Prevention Program. The virtual program’s goal for members is to achieve a 5%-7% weight reduction.

**Social Groups** – Getting healthier and learning something new is easier with friends. Join a group to stay motivated, chat with others, and achieve goals together. Learn easy ways to get more active, eat well, and manage life’s ups and downs – every day!

**Whil Mindfulness** – Breathe. Your personal stress reliever is here. Watch meditation videos by Whil, a leader in employee wellness, and learn how to practice mindfulness.

**Journeys® Digital Coaching** – Want to exercise more? Or better manage a health issue? Now you can use our digital coaching tool, Journeys, to make simple changes to your health, one small step at a time.

**Phone Coaching** – Talk to a professional clinician and coach over the phone to get one-on-one support, expert guidance and help navigating your health care questions.

**Challenges** – Rally your co-workers for the latest step challenge or to start a new healthy habit.

Beginning July 1, 2020, visit [join.virginpulse.com/StateofOhio](http://join.virginpulse.com/StateofOhio) to see all of the benefits available to you, and to begin working taking the steps you need to improve your health and earn rewards.

### Enrollment

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

## DENTAL (FOR EXEMPT EMPLOYEES ONLY)

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.

Service time for employees classified as student help, college interns or whose appointments are temporary, seasonal or intermittent may count toward one year of continuous State service if such employees are hired on a permanent, full-time basis or permanent part-time basis with no break in service.

#### Dependent Eligibility

##### 1. Spouse

- Your current legal spouse as recognized by Ohio law, who is not already enrolled as a State employee under their own OH|ID Workforce User ID

##### 2. Children younger than age 19:

- 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
- Foster children
- Children for whom either you or your spouse has been appointed legal guardian
- 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](https://das.ohio.gov/forms) in the "Eligibility" section, and
- A "Current Enrollment Verification Certificate" from the National Student Clearinghouse, [studentclearinghouse.org](https://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 reenrolled 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 medical plan. 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](https://das.ohio.gov/eligibilityrequirements).



**FOR UNION-REPRESENTED EMPLOYEES**  
Union-represented employees receive dental, vision, life and legal plan benefits through Union Benefits Trust (UBT). For more information about these benefits, visit [benefitstrust.org](https://benefitstrust.org).

## 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 Dental pays the least for out-of-network dentists.

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

[deltadentaloh.com](http://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](http://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 6.



## DELTA DENTAL PLAN FOR EXEMPT EMPLOYEES

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist**
<b>Benefit Year* Maximum</b>	\$1,500	\$1,500	\$1,500
<b>Diagnostic and Preventive Services (e.g., X-rays, oral cleanings)</b>	100%	100%	100%
<b>Basic Restorative Services (e.g., fillings)</b>	100%	65%	65%
<b>Major Restorative Services (e.g., crowns, bridges)</b>	60%	50%	50%
<b>Orthodontia</b>	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 prophylaxes or 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. Any expenses incurred by an eligible person for covered services during the last three months of a benefit year and applied to the deductible for that benefit year will also be applied to the deductible for the following benefit year.

All services except orthodontia, implants, and stents apply toward the benefit maximum. 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 DENTAL 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.

Service time for employees classified as student help, college interns or whose appointments are temporary, seasonal or intermittent may count toward one year of continuous State service if such employees are hired on a permanent, full-time basis or permanent part-time basis with no break in service.

#### Dependent Eligibility

##### 1. Spouse

- Your current legal spouse as recognized by Ohio law, who is not already enrolled as a State employee under their own OH|ID Workforce User ID.

##### 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
- Foster children
- Children for whom either you or your spouse has been appointed legal guardian
- 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](https://das.ohio.gov/forms) in the "Eligibility" section, and
- A "Current Enrollment Verification Certificate" from the National Student Clearinghouse, [studentclearinghouse.org](https://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 reenrolled 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 medical plan. 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](https://das.ohio.gov/eligibilityrequirements).

### Specific Benefit Information

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

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](https://eyemed.com)  
888-838-4033  
Group Number: 1016475

## EYEMED VISION CARE PLAN FOR EXEMPT EMPLOYEES

Benefit Frequency (Based on last date of service)	In-Network	Out-of-Network
<b>Routine Exam/Frame/Lens</b>	Once every 12 months	Once every 12 months
Service	Your In-Network Cost	Your Out-of-Network Reimbursement*
<b>Exam</b> Dilation as necessary	\$10 co-pay \$0	Up to \$25
Refraction	\$0	
<b>Retinal Imaging</b>	Up to \$39	N/A
<b>Exam Options – Contact Lenses</b> Standard Fit and Follow-up Premium Fit and Follow-up	Up to \$40 90% of retail price	N/A
<b>Frames</b>	\$0 copay, plus 80% of balance over \$120	Up to \$18
<b>Standard Plastic Lenses</b>		
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
<b>Standard Lens Options</b>		
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
<b>Contact Lenses**</b>		
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
<b>LASIK or PRK from US Laser Network</b>	85% of retail price, or 95% of promotional price, whichever is less	N/A
<b>Low Vision</b>		
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.

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](http://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 6.



**FOR UNION-REPRESENTED EMPLOYEES**

Union-represented employees receive dental, vision, life and legal plan benefits through Union Benefits Trust (UBT). For more information about these benefits, visit [benefitstrust.org](http://benefitstrust.org).

## LIFE INSURANCE (FOR EXEMPT EMPLOYEES)

### BASIC LIFE INSURANCE

The State of Ohio provides basic life insurance coverage through Securian Financial, a policy underwritten by Minnesota Life Insurance Company, 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.

MONTHLY CONTRIBUTIONS PER \$1,000 OF BASIC LIFE INSURANCE COVERAGE			
	Employee Share	State Share	Total
<b>Basic Life</b>	\$0	\$0.118	\$0.118
<b>OAD&amp;D</b>	\$0	\$0.012	\$0.012

#### Eligibility

##### Employees

Exempt full-time and part-time permanent employees are offered basic life insurance following the completion of one year of continuous State service. If you are eligible for basic life insurance as an exempt employee and have a spouse that is also an exempt State of Ohio employee, you cannot be covered as a dependent under their supplemental life insurance coverage.

##### 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 to the right 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 IRS Basic Life Imputed Income chart.

#### 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 Securian Financial website at [lifebenefits.com](http://lifebenefits.com).

Alternatively, you may submit a beneficiary form by mail to Securian Financial. This form is available in the Forms page, [das.ohio.gov/forms](http://das.ohio.gov/forms), on the Employee Benefits website.

#### 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 are eligible to purchase supplemental life insurance coverage provided by Securian Financial, a policy underwritten 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 32.

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 are eligible for supplemental life insurance on their date of hire or promotion or thereafter during Open Enrollment.

#### Dependents

Spouses and eligible dependent children up to age 26 of exempt employees are eligible for exempt supplemental life insurance.

However, only one exempt State of Ohio employee may cover the same eligible dependent child. In addition, your spouse is not eligible for spouse supplemental life coverage if they are eligible for employee basic and/or supplemental life insurance coverage as an exempt State of Ohio employee.

### Specific Benefit Information

#### Coverage Levels

##### Employees

##### Initial Eligibility

- 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 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 Securian Financial.
- 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

### 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 dependent children younger than age 26 up to \$7,000 for 82 cents per month, regardless of how many children you cover. Evidence of insurability is not required.

## 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 Securian Financial website at [lifebenefits.com](http://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](http://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 Securian Financial.
- 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 Securian Financial.

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 Securian Financial based upon medical underwriting results.

For questions regarding supplemental life insurance, contact Securian Financial 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-Nicotine Rate/\$10,000/Month		Nicotine Rate/\$10,000/Month	
	Employee	Spouse	Employee	Spouse
Under 25	\$0.49	\$0.50	\$0.64	\$0.67
25-29	\$0.49	\$0.60	\$0.64	\$0.81
30-34	\$0.60	\$0.80	\$0.80	\$1.08
35-39	\$0.80	\$0.90	\$0.95	\$1.21
40-44	\$1.00	\$1.00	\$1.45	\$1.34
45-49	\$1.50	\$1.50	\$2.42	\$2.02
50-54	\$2.30	\$2.30	\$3.73	\$3.09
55-59	\$4.30	\$4.30	\$5.54	\$5.78
60-64	\$6.60	\$6.60	\$8.49	\$8.87
65-69	\$12.70	\$12.70	\$15.24	\$17.07
70 and older	\$20.00	\$20.60	\$27.29	\$27.69



## DISABILITY BENEFITS

The State of Ohio offers eligible employees disability leave benefits. These benefits provide financial assistance in the event 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
- 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
- Any illness occurring after separation from State service

#### Payment While on Disability Leave

Disability benefits are paid at 67% 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 that is the same or similar to your current State of Ohio position, or has the same or similar physical requirements
- 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
- 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](http://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*

#### Disability Claims

If your attending physician or treating provider determines that your non-work-related injury or illness will prevent you from working for 15 or more consecutive calendar days, you may be eligible to apply for disability leave benefits. To file your claim, log in to **myOhio.gov>My Workspace>myBenefits** and click **Create/Extend a Disability Claim**. Your physician or treating provider will need to complete an Attending Physician Statement. If you are unable to file online, contact your agency human resources representative to obtain the Initial Application for Disability Leave Benefits.

All disability applications must be returned to your agency human resources representative within 20 calendar days from your last day of work. For questions regarding the disability claim filing process/requirements, contact your agency human resources representative.



## 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.

Employees with State of Ohio health insurance who are receiving, or awaiting determination of, a State-employment related, lost time Workers' Compensation claim can continue to be eligible for health insurance at no cost to them for up to 12 months. The employee can continue to be eligible for health insurance at the usual cost share paid by the employee for an additional period of up to 12 months. The employee may arrange for a payment plan with the State for the second 12 month period. The State has the right to recover such payments if the Workers' Compensation claim is determined to be non-compensable.\*

*\* This excerpt applies only to employees referenced in the Ohio Civil Service Employees Association Contract 2018-2021, Article 34:01. Employees of other collective bargaining units, including the Auditor of State, Ohio Attorney General, Secretary of State, and Treasurer of State should refer to their applicable collective bargaining agreement.*

### Eligibility

All State employees are eligible for benefits offered by 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 BWC. You and your attending physician will need to file a Request for Temporary Total Compensation (Form C-84). Your physician 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](http://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
- 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% 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% 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% 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 within their budget.

#### 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](https://das.ohio.gov/wilmapc) and click 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](https://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](https://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% of his or her regular rate of pay in lieu of workers' compensation temporary total benefits if an approved 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 within their budget.

#### Eligibility

Occupational Injury Leave (OIL) is available to full-time or part-time permanent 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](https://das.ohio.gov/wilmapc) and click 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](https://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 MED-CO-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](https://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 within their budget.

#### 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 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](https://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 toward any buy back. 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](https://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](https://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
- Enroll within 31 days of successfully completing probation, if applicable

Enrollment forms are located at [das.ohio.gov/forms](https://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
- Following a change in status/qualifying event

These benefits require annual enrollment.

#### Important Notice: Health Care Spending Account vs. Ohio Med HDHP Enrollment

Employees and/or spouses currently enrolled the Ohio Med HDHP (high deductible health plan) with the health savings account (HSA) are not eligible to enroll in a traditional Health Care Spending Account. Conversely, if you or your spouse enroll in a Health Care Spending Account for calendar year 2020, neither you nor your spouse is eligible to enroll in the Ohio Med HDHP with an HSA in the Spring of 2020. This also applies if you will have a carryover balance in your Health Care Spending Account as of Dec. 31, 2019.

### LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

If you are enrolled in a qualified high-deductible health plan (HDHP) and have a Health Savings Account (HSA), you can maximize your savings with WageWorks Limited Purpose Flexible Spending Account (FSA). This pre-tax account helps you save on eligible out-of-pocket dental and vision expenses.

Note: This account can only be used for reimbursement of qualifying dental and vision expenses. It cannot be used for medical expenses.

#### Cost

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

#### Eligibility

You must meet the qualifications for a Health Care Spending Account (HCSA). This includes being a permanent employee who has completed an initial probationary period, if applicable, and have sufficient pay to cover the election amount. Additionally, you must:

- Be enrolled or planning to enroll in the State's HDHP
- You qualify for, and elect to contribute to, a Health Savings Account and ensure your spouse is not enrolled in the standard Health Care Spending Account with her/his employer

Enrollment must occur within 31 days of eligibility or during the Flexible Spending Account open enrollment period. If you complete your initial probationary period between Oct. 1 and Dec. 31, you are eligible to enroll during Open Enrollment for the next plan year.

The Limited Purpose FSA is used to pay for eligible dental and vision expenses not paid for by your insurance or other plan. These expenses can be incurred by you, your spouse, or a qualifying child or relative. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate.



## Specific Benefit Information

Annual Limited Purpose FSA Limits:

- Minimum Annual Deposit: \$240
- Maximum Annual Deposit: \$2,500

Remember that the limit is per employee, so if you have a spouse with a Limited Purpose FSA, they can contribute up to \$2500 in their account as well, even if you both work for the State of Ohio.

### Carryover

You may carryover a minimum of \$50 and a maximum of \$500 from one plan year to the next. This means that if you have between \$50 and \$500 remaining in your Limited Purpose FSA on December 31, 2020, you can transfer that amount to the 2021 plan year. Keep in mind that you must use current year funds before using carryover funds.

- Minimum Carryover: \$50
- Maximum Carryover: \$500

### Limited Purpose FSA Fund Availability

Once you sign up for a Limited Purpose FSA and decide how much to contribute, the maximum amount of your annual contribution will be available for reimbursement of eligible dental and vision expenses throughout your period of coverage.

Since you don't have to wait for the funds to accumulate in your account, you can use it to pay for eligible dental and vision expenses once your account becomes effective.

Note: For employees on a biweekly pay schedule, deductions will be taken from the first 24 pay periods of the calendar year.

### Eligible Expenses for a Limited Purpose FSA:

- Dental care, both preventive and restorative
- Orthodontia, child and adult
- Vision care, eyeglasses, contacts lenses, and solutions
- Eye surgery, including laser vision correction

### Ineligible Expenses for a Limited Purpose FSA:

- Medical products and services
- Prescription drugs
- Mental health services

See [wageworks.com/mynewfsa](https://wageworks.com/mynewfsa) for more information.

### Health Care Spending Account vs. Ohio Med HDHP Enrollment

Employees and/or spouses enrolled the Ohio Med HDHP HSA are not eligible to enroll in a traditional Health Care Spending Account. Conversely, if you or your spouse enroll in a Health Care Spending Account for calendar year 2020, neither you nor your spouse is eligible to enroll in the Ohio Med HDHP with an HSA in the calendar year 2020. This also applies if you have a carryover balance in your Health Care Spending Account as of Dec. 31, 2019.

### Enrollment

Enroll within 31 days of the hire date or change in status/qualifying event. Enrollment forms are located at [das.ohio.gov/forms](https://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
- Following a change in status/qualifying event

These benefits require annual enrollment.

For more detailed information about Flexible Spending Accounts, visit [das.ohio.gov/flexiblespendingaccounts](https://das.ohio.gov/flexiblespendingaccounts).

## 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](https://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](https://das.ohio.gov/forms).

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

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

These benefits require annual enrollment.

For more detailed information about Flexible Spending Accounts, visit [das.ohio.gov/flexiblespendingaccounts](https://das.ohio.gov/flexiblespendingaccounts).

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## 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
- 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](https://das.ohio.gov/commuterchoiceprogram).

The 2020 IRS monthly allowable dollar limit for transit is \$270. When you enroll for the Commuter Choice transit benefit, the fare pass will be delivered directly to your mailing address.

The 2020 IRS monthly allowable dollar limit for parking is \$270. 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](https://wageworks.com).

## Family Extended Benefits

State of Ohio employees may now purchase transit passes, such as bus, train, subway, ferry, or van pool for family members or dependents for whom they pay transit costs. This additional benefit applies only to transit costs and does not include parking costs.

If you are not currently enrolled in the Commuter Choice Program, you can enroll to purchase a transit pass for a family member with pre-tax dollars. If you are already enrolled and contribute less than the monthly pre-tax maximum of \$265, you can now increase your pretax deductions up to the maximum and order a transit pass for a family member. The more pre-tax money you contribute to the benefit program, the more you save on taxes.

There is no need to wait for the Open Enrollment period; you can sign up any time. Keep in mind that orders must be placed a month in advance. You must place orders by the 5th of the current month for benefits to be effective the next month.

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

**NOTICE OF PRIVACY PRACTICES**

**Effective July 1, 2020**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

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

**Position on Privacy**

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

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

**How the Plan May Use or Disclose Your Protected Health Information**

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

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

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

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

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

that may be available to you. The Plan may also combine your health information with that of other enrolled persons to evaluate the coverage provided and the quality of care received.

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

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

- A. **As Required By Law.** The Plan may disclose your PHI when required by federal, state or local law.
- B. **Family and Individuals Involved in Your Care.** The Plan may disclose medical information about you to a family member or friend who is involved in your medical care. The Plan may request that your family members verify their identity and demonstrate they are acting on your behalf.
- C. **To Avert a Serious Threat to Health or Safety.** The Plan may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public.
- D. **Public Health Activities.** The Plan may use and disclose medical information about you for public health activities including activities related to preventing and controlling disease or, when required by law, to notify public authorities concerning cases of abuse or neglect.
- E. **Victims of Abuse, Neglect, or Domestic Violence.** The Plan may disclose medical information to a government authority, including a social service or protective agency if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence.
- F. **Health Oversight Activities.** The Plan may disclose medical information to a health oversight agency for oversight activities authorized by law, such as: overall health care system monitoring, monitoring the conduct of government programs, and monitoring to ensure compliance with civil rights laws.
- G. **Lawsuits/Legal Disputes.** The Plan may use and disclose medical information about you in the course of an administrative or judicial proceeding, such as in response to a subpoena, discovery request, warrant, or a lawful court order.
- H. **Law Enforcement Purposes.** The Plan may disclose medical information to law enforcement officials for law enforcement purposes including investigation of a crime or to identify or locate a suspect, fugitive, material witness or missing person.
- I. **Specialized Government Functions.** The Plan may disclose medical information to authorized federal officials for the purposes of intelligence, counterintelligence, and other national security activities authorized by law.
- J. **Military.** If you are a member of the armed forces, the Plan may disclose medical information about you as required by military command authorities.
- K. **Organ, Eye and Tissue Donation.** If you are an organ donor, the Plan may disclose information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- L. **Workers' Compensation.** The Plan may disclose medical informa-



tion about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- M. **Coroners, Medical Examiners, and Funeral Directors.** The Plan may disclose medical information to a coroner or medical examiner to, for example, identify a deceased person or determine the cause of death. The Plan may also disclose medical information about patients to funeral directors as necessary to carry out their duties.
- N. **Business Associates.** The State contracts with parties who provide necessary services for the operation of its plans. For example, the Plan is assisted in its operations by third party administrators. These persons who assist the Plan are called business associates. At times, the Plan may use and disclose PHI so they can provide services. The Plan will require that any business associates who receive PHI safeguard the privacy of that information.
- O. **Disclosure to You.** The Plan may disclose your medical information to you.

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

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

### 4. Changes to Existing Laws

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

### Your Legal Rights

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

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

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

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

**Right to Inspect and Copy Your Information.** You have the right, in most cases, to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Plan's HIPAA Privacy Contact listed below. If you request a copy of the information, the Plan may charge a fee for the costs of copying,

mailing, or other unusual supplies associated with your request. Under Ohio and federal law, the Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

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

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

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

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

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

### This Notice Is Subject To Change

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

### Whom to Contact

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

#### US Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, D.C. 20201

1-877-696-6775

[www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints)

#### The Plan's HIPAA Privacy Contact

Gregory Pawlack

DAS – HIPAA Privacy Contact

30 East Broad St., 27th Floor

Columbus, Ohio 43215

614-466-6205

[gregory.pawlack@das.ohio.gov](mailto:gregory.pawlack@das.ohio.gov)

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

## NOTICE OF INITIAL COBRA RIGHTS

### \*\* Continuation Coverage Rights Under COBRA \*\*

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

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

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

### SPECIAL ENROLLMENT RIGHTS PURSUANT TO HIPAA

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

The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and

any dependents should all take the time to read the entire notice carefully.

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

To request special enrollment or to obtain additional information about this notice, please contact your Plan Administrator listed below:

#### State of Ohio

Department of Administrative Services  
Benefits Administration Services  
Medical Plan Benefits Manager

30 East Broad Street, 27th Floor  
Columbus, Ohio 43215  
(800) 409-1205 (option 2)

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

### WELLNESS PROGRAM NOTICE

Take Charge | Live Well is a voluntary wellness program available to employees and spouses 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 of 1996, as applicable, among others.

If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment (HRA) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will have the opportunity 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, enrolled employees and/or spouses 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.

Employees and spouses can earn participation-based incentives and outcome-based incentives for more rewards. 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 DAS Employee Benefits Management Team at 800-409-1205, option 2.

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 the tobacco cessation program. You are also encouraged to share your results or concerns with your own doctor.

### Protections from Disclosure of Medical Information

The Take Charge | Live Well program is 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 neces-

sary 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 Virgin Pulse, Inc., the State wellness program's third-party administrator, 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, you will be notified 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.

For questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the DAS Employee Benefits Management Team at 800-409-1205, option 2.

#### **THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998**

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

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

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

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

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

#### **THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

Under the provisions of The Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than

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

#### **PATIENT PROTECTION DISCLOSURE**

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

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

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

#### **CREDITABLE COVERAGE DISCLOSURE FOR THE OHIO MED PPO PLAN:**

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

Please read this notice carefully and keep it where you can find it. For those enrolled in the Ohio Med PPO Plan, this notice has information about your current prescription drug coverage with the State of Ohio and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- The State of Ohio has determined that the prescription drug coverage offered under the Ohio Med PPO Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

##### **When can you join a Medicare drug plan?**

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

month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

Go to: [das.ohio.gov/prescriptiondrug](https://das.ohio.gov/prescriptiondrug) for more details on your prescription benefits.

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

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

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

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

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

For further information, contact:

#### **State of Ohio**

Department of Administrative Services  
Benefits Administration Services  
Medical Plan Benefits Manager

30 East Broad Street, 27th Floor  
Columbus, Ohio 43215  
(800) 409-1205 (option 2)

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](https://www.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](https://www.socialsecurity.gov) or

call them at 1-800-772-1213 (TTY 1.800.325.0778).

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

### **CREDITABLE COVERAGE DISCLOSURE FOR THE OHIO MED HDHP PLAN:**

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

Please read this notice carefully and keep it where you can find it. For those enrolled in the Ohio Med HDHP Plan, this notice has information about your current prescription drug coverage with the State of Ohio and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- The State of Ohio has determined that the prescription drug coverage offered by the Ohio Med HDHP Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### **When can you join a Medicare drug plan?**

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

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

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

Go to: [das.ohio.gov/prescriptiondrug](https://das.ohio.gov/prescriptiondrug) for more details on your prescription benefits.

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

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

You should also know that if you drop or lose your current coverage with the State of Ohio and don't join a Medicare drug plan within 63

continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

For further information, contact:

##### **State of Ohio**

Department of Administrative Services  
Benefits Administration Services  
Medical Plan Benefits Manager

30 East Broad Street, 27th Floor  
Columbus, Ohio 43215

(800) 409-1205 (option 2)

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](http://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](http://socialsecurity.gov) or call them at 1-800-772-1213 (TTY 1.800.325.0778).

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

#### **NONDISCRIMINATION AND ACCESSIBILITY STATEMENT**

##### **Discrimination is Against the Law**

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

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

If you believe that you've been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with your agency's EEO Officer, or you may file a complaint with the DAS Equal Opportunity Division at:

(Website: [www.das.ohio.gov/eod/aaeeo](http://www.das.ohio.gov/eod/aaeeo)) (Phone: 614-466-8380).

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

#### **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](http://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](http://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](http://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, 2020. Contact your State for more information on eligibility.**

**ALABAMA - Medicaid**

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

**ALASKA - Medicaid**

The AK Health Insurance Premium Payment Program  
 Web: <http://myakhipp.com>  
 Phone: 1-866-251-4861  
 Email: [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)  
 Medicaid Eligibility:  
[http://dhss.alaska.gov/dhcs/Pages/medicaid\\_medicare/default.aspx](http://dhss.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx)

**ARKANSAS - Medicaid**

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

**CALIFORNIA - Medicaid**

Web: [https://www.dhcs.ca.gov/services/Pages/TPLRD\\_CAU\\_cont.aspx](https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx)  
 Phone: 1-800-541-5555

**COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**

Health First Colorado Website:  
<https://www.healthfirstcolorado.com>  
 Health First Colorado Member Contact Center:  
 1-800-221-3943/ State Relay 711  
 CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>  
 CHP+ Customer Service: 1-800-359-1991/ State Relay 711

**FLORIDA - Medicaid**

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

**GEORGIA - Medicaid**

Medicaid Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>  
 Phone: 678-564-1162 ext 2131

**INDIANA - Medicaid**

Healthy Indiana Plan for low-income adults 19-64  
 Web: [www.in.gov/fssa/hip](http://www.in.gov/fssa/hip)  
 Phone: 1-877-438-4479  
 All other Medicaid  
 Web: [www.indianamedicaid.com](http://www.indianamedicaid.com)  
 Phone 1-800-403-0864

**IOWA - Medicaid and CHIP (Hawki)**

Web: <https://dhs.iowa.gov/ime/members>  
 Medicaid Phone: 1-800-338-8366  
 Hawki Website: <http://dhs.iowa.gov/Hawki>  
 Hawki Phone: 1-800-257-8563

**KANSAS - Medicaid**

Web: <http://www.kdheks.gov/hcf/default.htm>  
 Phone: 1-800-792-4884

**KENTUCKY - Medicaid**

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>  
 Phone: 1-855-459-6328  
 Email: [KIHIPPPROGRAM@ky.govKCHIP](mailto:KIHIPPPROGRAM@ky.govKCHIP)  
 Web: <https://kidshealth.ky.gov/Pages/index.aspx>  
 Phone: 1-877-524-4718  
 Kentucky Medicaid Website: <https://chfs.ky.gov>

**LOUISIANA - Medicaid**

Web: [www.medicaid.la.gov](http://www.medicaid.la.gov) or [www.ldh.la.gov/lahipp](http://www.ldh.la.gov/lahipp)  
 Phone: 1-888-342-6207 (Medicaid hotline)  
 or 1-855-618-5488 (LaHIPP)

**MAINE - Medicaid**

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

**MASSACHUSETTS - Medicaid and CHIP**

Web: [www.mass.gov/eohhs/gov/departments/masshealth](http://www.mass.gov/eohhs/gov/departments/masshealth)  
 Phone: 1-800-862-4840

**MINNESOTA - Medicaid**

Web: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp>  
 [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739

**MISSOURI - Medicaid**

Web: [www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
 Phone: 573-751-2005

**MONTANA - Medicaid**

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

**NEBRASKA - Medicaid**

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

**NEVADA - Medicaid**

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

**NEW HAMPSHIRE - Medicaid**

Web: [www.dhhs.nh.gov/oii/hipp.htm](http://www.dhhs.nh.gov/oii/hipp.htm)  
 Phone: 603-271-5218  
 Toll-Free: 1-800-852-3345, ext 5218

**NEW JERSEY - Medicaid and CHIP**

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

**NEW YORK - Medicaid**

Web: [www.health.ny.gov/health\\_care/medicaid](http://www.health.ny.gov/health_care/medicaid)  
 Phone: 1-800-541-2831

**NORTH CAROLINA - Medicaid**

Web: <https://medicaid.ncdhhs.gov>  
 Phone: 919-855-4100

**NORTH DAKOTA - Medicaid**

Website:  
<http://www.nd.gov/dhs/services/medicalserv/medicaid>  
 Phone: 1-844-854-4825

**OKLAHOMA - Medicaid and CHIP**

Web: [www.insureoklahoma.org](http://www.insureoklahoma.org)  
 Phone: 1-888-365-3742

### OREGON - Medicaid

Website:

<http://healthcare.oregon.gov/Pages/index.aspx>  
<http://www.oregonhealthcare.gov/index-es.html>

Phone: 1-800-699-9075

### PENNSYLVANIA - Medicaid

Website:

<https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>

Phone: 1-800-692-7462

### RHODE ISLAND - Medicaid

Web: <http://www.eohhs.ri.gov>

Phone: 855-697-4347 or  
401-462-0311 (Direct Rite Share Line)

### SOUTH CAROLINA - Medicaid

Web: [www.scdhhs.gov](http://www.scdhhs.gov) Phone: 1-888-549-0820

### SOUTH DAKOTA - Medicaid

Web: <http://dss.sd.gov> Phone: 1-888-828-0059

### TEXAS - Medicaid

Web: <http://gethipptexas.com> Phone: 1-800-440-0493

### UTAH - Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov>

CHIP Website: <http://health.utah.gov/chip>

Phone: 1-877-543-7669

### VERMONT - Medicaid

Web: [www.greenmountaincare.org](http://www.greenmountaincare.org)

Phone: 1-800-250-8427

### VIRGINIA - Medicaid and CHIP

Website: <https://www.coverva.org/hipp/Medicaid>

Phone: 1-800-432-5924

CHIP Phone: 1-855-242-8282

### WASHINGTON - Medicaid

Website: <https://www.hca.wa.gov> Phone: 1-800-562-3022

### WEST VIRGINIA - Medicaid

Web: <http://mywvhipp.com>

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

### WISCONSIN - Medicaid and CHIP

Web: [www.dhs.wisconsin.gov/publications/p1/p10095.pdf](http://www.dhs.wisconsin.gov/publications/p1/p10095.pdf)

Phone: 1-800-362-3002

### WYOMING - Medicaid

Website: <https://wyequalitycare.acs-inc.com>

Phone: 307-777-7531

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

#### U.S. Department of Labor

Employee Benefits Security Administration

[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)

1-866-444-EBSA (3272)

#### U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

[www.cms.hhs.gov](http://www.cms.hhs.gov)

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

## 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, body mass index (BMI), 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.

**Chronic Disease Management:** An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve your quality of life while reducing your health care costs if you have a chronic disease by preventing or minimizing the effects of a disease.

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

**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%.

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

**Dependent Care Spending Account (DCSA):** A pre-tax benefit account used to pay for dependent care services while you are at work. The money you contribute to a Dependent Care Spending Account is not subject to payroll taxes, so you end up paying less in taxes and taking home more of your paycheck. Under this type of account, a "dependent" is a child under 13 years of age (until the day of their 13th birthday) and adult dependents who can't take care of themselves. The dependent(s) must live with you and be claimed as dependents on your tax return.

**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.

**Emergency Room:** The department of a hospital that provides immediate treatment for acute illnesses and trauma. An emergency room visit typically costs more than a walk-in clinic or an urgent care center.



**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.

**Health Savings Account (HSA):** A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance and some other expenses, you can lower your overall health care costs. An HSA can be used only if you have a high deductible health plan (HDHP).

**Health Care Spending Account (HCSA):** A pre-tax benefit account that you can use to pay for eligible medical, dental, and vision care expenses that aren't covered by your health insurance plan. You decide how much to contribute to your HCSA each year, and funds are withdrawn automatically from each paycheck for deposit into your account before taxes are deducted. The total amount you elect to contribute to your HCSA each year is available on the first day of your plan year.

**High Deductible Health Plan (HDHP):** A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible). An HDHP plan can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes.

**Limited Purpose Flexible Spending Account (LPFSA):** A Limited-Purpose FSA can be used to pay for a variety of dental and vision care products and services for you, your spouse, and your dependents. The IRS determines which expenses are eligible for reimbursement. You can view a comprehensive list of eligible expenses by logging into your WageWorks account.

**Open Enrollment Period:** The yearly period when you can enroll in a health insurance plan for yourself and your dependent(s). During the Open Enrollment period, you are eligible if you have certain life events, such as getting married, having a baby or losing other health coverage.

**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% 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.

**Reasonable Alternative/Reasonable Alternative Standard:** A reasonable alternative is allowed for anyone for whom it is medically inadvisable to try to meet the health goal in an activity-based wellness program. For example, tobacco cessation is a common target health result. Completion of a tobacco cessation program is a common reasonable alternative standard for obtaining a reward.

**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](http://das.ohio.gov/benefits).

**Telehealth:** Visiting with a doctor, therapist, or psychiatrist using a smartphone, tablet, or computer with a webcam.

**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, 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.

**Urgent Care Center:** Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe that it requires emergency room care. An urgent care typically costs less than an emergency room visit, but more than a walk-in clinic.

**Walk-in Clinic:** A facility that offers limited health care services without an appointment. A walk-in clinic typically costs less than an urgent care center or an emergency room visit.

## HEALTH AND OTHER BENEFITS CONTACTS

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### ALL EMPLOYEES

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#### Medical

[Anthem](#)

844-891-8359

Nurse Line: 800-337-4770

[enrollmentanthem.com/stateofohio](https://enrollmentanthem.com/stateofohio)

Group Number: 004007521

[Medical Mutual of Ohio](#)

800-822-1152

Nurse Line: 888-912-0636

[stateofohio.medmutual.com](https://stateofohio.medmutual.com)

Group Number: 228000

#### Health Savings Account

[Optum Bank](#)

844-449-4540

[optumbank.com/myohiohsa](https://optumbank.com/myohiohsa)

#### Telehealth

[LiveHealth Online](#)

888-548-3432

[livehealthonline.com](https://livehealthonline.com)

#### Prescription Drug

[OptumRx](#)

866-854-8850

[optumrx.com](https://optumrx.com)

Rx Group Number: STOH

#### Behavioral Health and Substance Use

[Optum Behavioral Solutions](#)

800-852-1091

[liveandworkwell.com](https://liveandworkwell.com)

Group Number: 1507

Website Access Code: 00832

[Ohio Employee Assistance Program](#)

800-221-6327

[ohio.gov/eap](https://ohio.gov/eap)

#### Take Charge | Live Well

[Virgin Pulse](#)

833-977-2074

(Available July 1, 2020)

[join.virginpulse.com/StateofOhio](https://join.virginpulse.com/StateofOhio)

#### Flexible Spending Accounts and Commuter Choice

[WageWorks](#)

855-428-0446

[wageworks.com](https://wageworks.com)

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### EXEMPT EMPLOYEES ONLY

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#### Dental

[Delta Dental of Ohio](#)

800-524-0149

[deltadentaloh.com](https://deltadentaloh.com)

Delta Dental PPO

Group Number: 9273-0001

#### Vision

[EyeMed Vision Care](#)

888-838-4033

[eyemed.com](https://eyemed.com)

Group Number: 1016475

#### Life Insurance

[Basic Life Insurance and Supplemental Life Insurance](#)

Securian Financial, a policy underwritten by Minnesota Life  
1-866-416-8832

[lifebenefits.com](https://lifebenefits.com)

Group Number: 34301

*Initial logon credentials for life insurance:* The initial user ID is "OH" plus your OH|ID Workforce User ID. The initial password is your date of birth (MMDDYYYY) plus the last four digits of your Social Security number.

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### UNION-REPRESENTED EMPLOYEES ONLY

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#### Union Benefits Trust

614-508-2255

800-228-5088

[customerservice@benefitstrust.org](mailto:customerservice@benefitstrust.org)  
[benefitstrust.org](https://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

[EyeMed Vision Care](#)

866-723-0514

Group Number: 9674813

[Vision Service Plan \(VSP\)](#)

800-877-7195

Group Number: 12022914

#### Life Insurance

[Prudential Life Insurance](#)

800-778-3827

Group Number: LG-01049

#### Legal Services

[Hyatt Legal Services](#)

800-821-6400

Group Number: 4900010

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### ALL EMPLOYEES

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#### Ohio Department of Administrative Services

[DAS Employee Benefits Management Team](#)

614-466-8857 (option 2) or

800-409-1205 (option 2)

Email:

[mybenefits@das.ohio.gov](mailto:mybenefits@das.ohio.gov)

Website: [das.ohio.gov/benefits](https://das.ohio.gov/benefits)

#### TIP:

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

- Group Number
- OH/ID Workforce User ID
- Explanation of Benefits if call is regarding a claim.



# Recovery from drug addiction is possible

[TakeChargeOhio.org/GetHelp](https://TakeChargeOhio.org/GetHelp)



Brought to you by Governor DeWine's RecoveryOhio initiative and the Ohio Department of Mental Health and Addiction Services. [RecoveryOhio.gov](https://RecoveryOhio.gov)

## Use telehealth to see a doctor at your convenience!

Use your smart phone, tablet, or webcam to visit with a board-certified doctor, licensed therapist, or board-certified psychiatrist

### Save time and money

Download the free LiveHealth Online app or visit [LiveHealthOnline.com](https://LiveHealthOnline.com)



The State of Ohio contracts with LiveHealth Online to provide telehealth services for employees and dependents enrolled in the State of Ohio medical plan. Register with LiveHealth Online so you're ready when you want to use it. Online visits available 24/7; therapy appointments typically available within four days or less.



**Ohio Department of Administrative Services**

Human Resources Division  
30 E. Broad St., 28th Floor  
Columbus, OH 43215

**SAVE THE DATES**

**2020**

**May**

Open Enrollment begins May 18  
and ends May 29

**June**

Benefit year ends June 30

**July**

New benefit year begins July 1

**October**

Flexible Spending Accounts Open  
Enrollment for calendar year 2021  
begins Oct. 19 and ends Oct. 30

**December**

Use your remaining Flexible Spending  
Accounts money for calendar year  
2020 by Dec. 31

**2021**

**January**

New Flexible Spending Accounts plan  
year begins Jan. 1

**March**

2020 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