UNION BENEFITS TRUST

HOW TO ENROLL IN YOUR DENTAL, VISION AND BASIC LIFE BENEFITS

FOR MEMBERS WITH AT LEAST ONE YEAR OF SERVICE

UNION BENEFITS TRUST

800.228.5088 614.508.2255

www.benefitstrust.org

Serving State of Ohio Union-Represented Employees

UBT

benefits

Dear UBT Member:

Congratulations! You have almost reached your one-year anniversary of state employment and as a member of the Union Benefits Trust (UBT).

The Union Benefits Trust's mission is:

To deliver high-quality benefits and services to Union-represented public employees, to enrich their overall quality of life and to enhance their appreciation of their respective unions.

As such, this guide was designed to help you begin to learn about the benefits for which you are now eligible.

These benefits are:

- Dental Coverage with Delta Dental
- Vision Coverage with EyeMed or VSP
- Basic Life Insurance with Prudential

You may enroll in dental and vision coverage online at **myOhio.gov** or by using a paper enrollment form available from your agency benefits representative or online at **benefitstrust.org**, under the Forms & Info Tab. Enrollment must occur within 31 days of your anniversary date. If you miss this deadline, the next opportunity to enroll is the next open enrollment period. Enrolling as soon as possible will help ensure that your coverage begins quickly, usually the first of the month after your employment anniversary date. Each plan will have costs at the time of service, but UBT pays the monthly premium costs for you and eligible family members.

UBT also pays the cost for the basic life insurance. You are automatically enrolled in the basic life plan and should declare a beneficiary as soon as possible. Designations can be made online or via paper. Visit **benefitstrust.org** for additional information/instructions on both options.

This booklet is intended to be a summary of your benefits. For more detailed information on these benefits, please visit **benefitstrust.org** or contact UBT customer service at **614-508-2255** or **800-228-5088** and **customerservice@benefitstrust.org**. Please keep your home address current with your Human Resources Department; all information including your anniversary and open enrollment kits will be mailed to your home.

We look forward to serving you.

Christopher A. Mabe
Chair, Union Benefits Trust
President, OCSEA, AFSCME Local 11
Trustees & Staff,
Union Benefits Trust

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INTRODUCTION

ABOUT THE TRUST

Union Benefits Trust exists to provide high-quality benefits and services to Union-represented public employees who work for the State of Ohio. Since 1993, UBT has offered benefits to Union-represented State employees, and currently serves approximately 35,000 employees represented by OCSEA/AFSCME Local 11, District 1199/SEIU, OSTA, FOP/OLC, SCOPE/OEA and CWA.

ABOUT THIS BOOKLET

This booklet describes three UBT benefits:

Dental Plan

This booklet describes the UBT Dental Plan effective July 1, 2010. This plan booklet replaces the prior booklet and is incorporated with the Administrative Services agreement with Delta Dental to form the complete contract. It contains highlights of the benefits offered by UBT. If a discrepancy exists between the information in this booklet and the Dental Plan Document, the Dental Plan Document prevails over this plan booklet.

Vision Plans

This booklet also describes the UBT Vision Plans effective July 1, 2014. It contains highlights of the benefits offered by UBT. If a discrepancy exists between the information in this booklet and the Vision Service Plan Document and addendum or the Vision Benefit Plan Agreement between Union Benefits Trust and EyeMed Vision Care, these documents prevail over this plan booklet.

Basic Life/AD&D

This booklet describes the UBT Basic Life insurance benefits effective July 1, 2014. If a discrepancy exists between the information in this booklet and the Basic Life Insurance booklet-certificate and the Group Insurance Contract from Prudential, the Group Insurance Contract prevails.

ANSWERING YOUR QUESTIONS

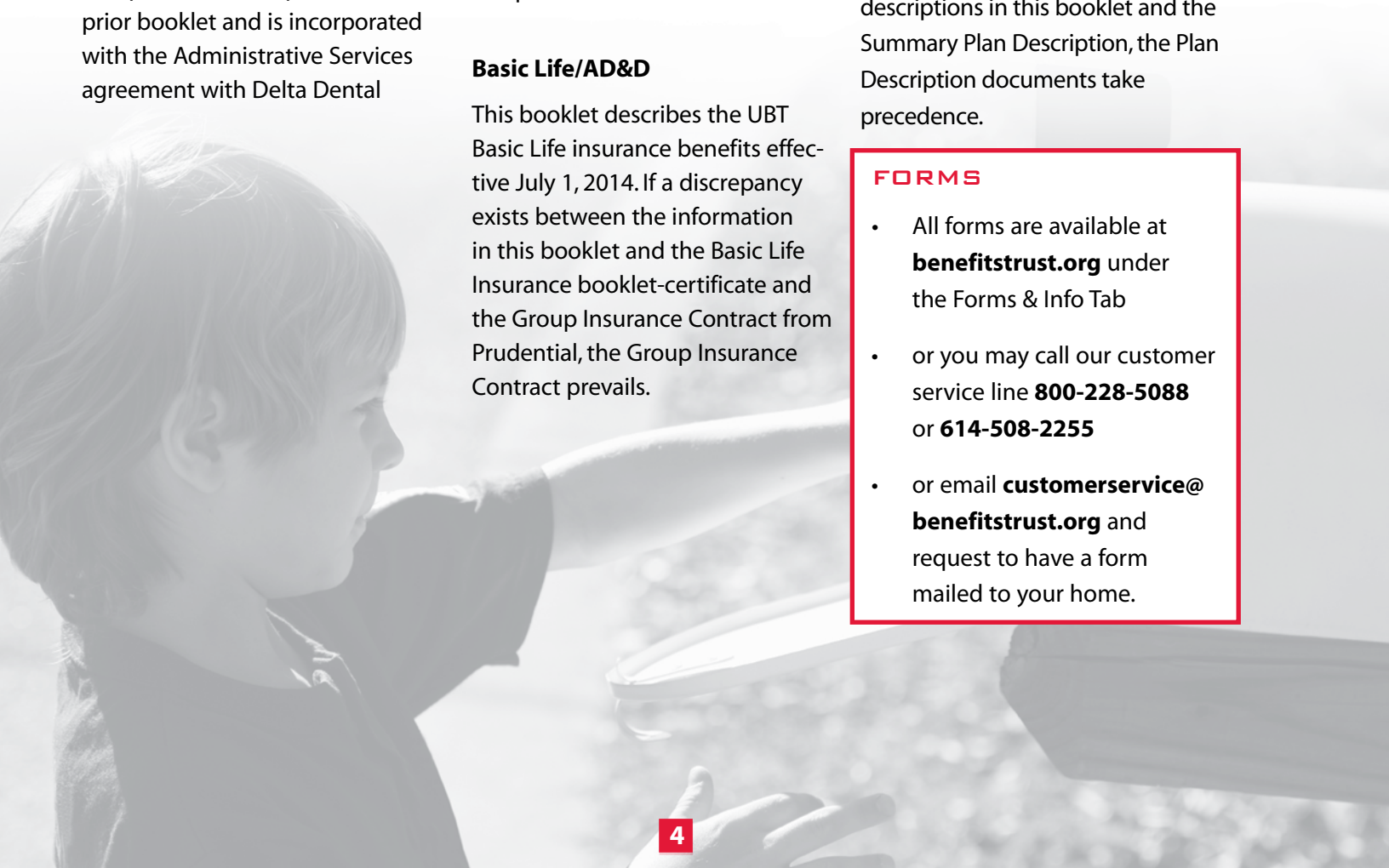
This booklet outlines eligibility requirements, benefits payable and benefit limitations. It has been specially designed to make it easier for you to find information you need to understand your benefits. We encourage you to use this summary as your first source of information when you have questions. If you cannot find an answer to your question, please contact UBT, Delta Dental, EyeMed, VSP or Prudential, using the information on the back cover of this booklet.

For eligibility questions, contact UBT at **800-228-5088**.

If a discrepancy exists between plan descriptions in this booklet and the Summary Plan Description, the Plan Description documents take precedence.

FORMS

- All forms are available at **benefitstrust.org** under the Forms & Info Tab
- or you may call our customer service line **800-228-5088** or **614-508-2255**
- or email **customerservice@benefitstrust.org** and request to have a form mailed to your home.



DENTAL & VISION ELIGIBILITY

EMPLOYEES

Members of participating Unions are eligible for dental and vision benefits after one year of continuous State service.

To be eligible, you must first be a full or part-time permanent employee and a member of:

- OCSEA/AFSCME
  Units 3-9, 13, 14, 45, 50, 55
- District 1199/SEIU
  Units 11, 12
- OSTA
  Units 1, 15
- FOP/OLC
  Units 2, 46, 48
- SCOPE/OEA
  Unit 10 or
- CWA
  Unit 40.

Established term employees are eligible unless excluded by an agency-specific agreement.

There is no premium cost to you for dental and vision coverage for yourself and/or your eligible dependents.

DEPENDENTS

If you, the member, are eligible for UBT benefits, you may cover your current legal spouse and unmarried dependent children, including those born to you, residential stepchildren, foster children, legally adopted children and children for whom you have legal guardianship. Dependent children must be dependent on you for support and maintenance.

Coverage for unmarried dependent children will end at age 19, unless you supply appropriate documentation of the following conditions:

- Children from age 19 until the end of the month in which they reach age 23 may be covered if they are primarily dependent on you for maintenance and support and are attending an accredited school.
- Children of any age who are primarily dependent on you and incapable of self-support due to developmental disabilities or physical handicap will be eligible as long as you maintain your eligibility.

To obtain eligibility, documentation is required and will need to be provided:

- when you first enroll
- when the child is first eligible
- for dependents over 19.

Coverage will not be provided for dependents until the eligibility documents are received and approved.

Details for required documentation for dependents is available at **benefitstrust.org**.

Your HR Representative can provide more details about the types of required documentation needed for dependent coverage.

A divorced spouse is not eligible as a dependent and no person is considered a dependent while in the armed forces. Any person living outside the United States or Canada is not considered a covered dependent.

Remember that if you are married and your spouse has coverage through his or her employer, coordinated benefits may apply. See the section on Coordinating Benefits on page 20.

TWO STATE EMPLOYEES IN THE FAMILY

When you and your spouse are both State employees, one may carry family coverage and the other single coverage, provided that the spouse is not listed as a dependent under family coverage. A child who is eligible for coverage as a State employee is not eligible as the dependent of a parent who is also a State employee.

Dental and vision benefits are not affected by the 2010 Health Care Reform Act (ACA).
As a result, dependents age 19 (or 23 if a student) cannot continue on your dental and vision coverage even though they may be covered under your health plan.

DENTAL & VISION ENROLLMENT AND CHANGES

EFFECTIVE DATES

Members who are actively at work can enroll in dental and vision coverage after one year of continuous State service. Coverage starts on the first day of the month following one continuous year of State service if you enroll within 31 days of becoming eligible.

For example, if your hire date is July 15, 2013, you must enroll within 31 days of July 15, 2014 for coverage to begin on August 1, 2014. If you do not enroll within 31 days of becoming eligible, you must wait until a Trust-sponsored open enrollment.

If you already have one year of service, you can enroll or make changes during open enrollment. Once enrolled, you may make changes at each subsequent Trust-sponsored open enrollment. Coverage elected during open enrollment will be effective on the July 1st following, as long as all appropriate forms are received by the enrollment deadline.

Coverage for enrolled dependents is effective on your effective date. Dependents you acquire after you enroll become eligible for coverage as shown on the Family Status Changes chart to the right, provided they are eligible and you enroll them for benefits by the appropriate deadline with the appropriate documentation.

COST OF COVERAGE

There is no premium for dental or vision coverage. UBT pays your dental and vision premiums.

ENROLLING

It is not necessary to enroll in medical health care to enroll in the UBT Dental or a Vision Plan.

You must enroll in the plan(s) to receive coverage, it is not automatic. Once enrolled, you do not need to enroll again unless you wish to make a change; however, it is important to review your coverage and dependents annually.

See page 7 for online enrollment instructions or you may complete a paper form and submit it to your HR. Forms are available at **benefitstrust.org** under the Forms & Info Tab. Online and paper enrollments must be completed within 31 days of your anniversary date.

If you do not enroll within 31 days of your anniversary date, you must wait until the next annual open enrollment period to obtain dental and/or vision coverage.

WHEN YOUR COVERAGE BEGINS

Typically, your dental and vision coverage will be effective the first day of your 13th month of continuous state service.

FAMILY STATUS CHANGES

You may change your coverage level (single or family) during the annual open enrollment or during the year if you have a family or employment-related status change that affects your coverage. Changes must be made within 31 days of the event or you will have to wait until the next Trust sponsored open enrollment to adjust your coverage level. Review the chart below, and see your HR Representative for more information.

Family status changes		
Change	Coverage Change Allowed	Date Change Effective
Marriage	Add dependent spouse (add spouse's children)	First of month following marriage
Birth or adoption	Add dependent child	Date of birth or placement in home
Divorce (you provided coverage)	Drop spouse	Last day of month in which divorce occurred
Death of dependent (you provided coverage)	Drop dependent	Last day of the month in which death occurred
Loss of coverage through spouse's employer due to layoff, termination, death or divorce	Enroll in coverage, add dependent	Date varies by type of change; see your HR Representative
Return to work through arbitration order or grievance settlement or administrative order	Re-enroll	Date varies by settlement agreement; see your HR Representative
Dependent return to school	Reinstate dependent coverage	1st month following term start date

ENROLLMENT INSTRUCTIONS

Enroll in dental and vision coverage online at: **myOhio.gov** or by using a paper enrollment form available online at **benefitstrust.org**, under the Forms & Info Tab, from your agency benefits representative or by calling UBT at **800-228-5088** or **614-508-2255**.

A. ONLINE

- You may enroll on-line at **myOhio.gov** beginning the second business day following your one-year anniversary date.
- Enter your State of Ohio User ID and password, click "SIGN IN;"
- On toolbar click HEALTH & BENEFITS Tab
- Select BENEFITS SUMMARY from drop down menu
- The Benefits Summary page will open;
- Click on "Enroll in Benefits"
- Click the "SELECT" button on the benefit enrollment page

Submit your selections through **myOhio.gov** within 31 days of your anniversary date. Make sure your online elections are correctly submitted and that you receive a confirmation message. Print and keep a copy for your records.

ONLINE ACCESS HOURS

Non-Payday Week
Mon. - Thurs. .. Available 24 hours/day
Friday..... All day until 7 pm
Sat. and Sun ... Unavailable

Payday Week
Mon. - Fri. ..... Available 24 hours/day
Saturday ..... All day except 4-6 pm
Sunday ..... Unavailable

B. PAPER

Obtain a paper dental and vision enrollment form
- online at **benefitstrust.org**,
- from your agency's human resource office,
- or call UBT at **800-228-5088** to have one mailed to your home.

Give the completed, signed and dated form to your agency's human resource office within 31 days of your anniversary date.

ENROLLING DEPENDENTS
If you are enrolling your dependent(s) in your dental and vision coverage, you are required to provide the required eligibility documentation for your dependents. A listing of the required documents can be found at: **das.ohio.gov/eligibilityrequirement.** Coverage will not be provided for dependents until the eligibility documents are received and approved by your agency's human resource office. If the required documentation is on file with your agency's human resource office as a result of enrolling in a medical plan, you may not need to resubmit.

Be sure you have a valid mailing address on file at **myOhio.gov**. Information regarding your benefits is mailed to that address from DAS and UBT. It is your responsibility to ensure that your current address is on file. You may list a P.O. Box as a mailing address but not as a home address.

BENEFIT REFERENCE CARDS FOR DENTAL AND VISION

A card is not required to receive services at your dental or vision provider's office for your convenience.

You have an option to print reference cards for you and your family's dental and vision benefit visits. Simply

1. link from UBT's website **benefitstrust.org** to Delta Dental & VSP.
2. register and create a password for a secure login.
3. print a card with your name and group number (which can be used for all family members).
4. for Eyemed, print reference card at **benefitstrust.org** under the VISION tab.

YOUR DENTAL & VISION COVERAGE

WHEN YOU ARE ON LEAVE

In some cases your dental and vision coverage may continue when you are not actively at work for the length of your authorized State leave. See your HR Representative for details.

WHEN YOUR COVERAGE ENDS

Generally, coverage is extended through the end of the month following the month state service terminates. For example, typically, if you leave State employment in July, and UBT receives a contribution in July, UBT will pay your last dental or vision premium for August. Your coverage would end August 31. However in certain circumstances, you may be able to continue your dental and vision benefits through COBRA. See page 21 for more information.

WHEN YOUR DEPENDENT(S) COVERAGE ENDS

Your dependent benefits will end on the last day of the month in which your dependent no longer meets the definition of an eligible dependent or the date your benefits end. See page 5 for dependent eligibility.

COBRA

You are responsible for notifying UBT when your dependent(s) is no longer eligible to receive dental and vision coverage under your benefits. ***At no time*** is your overage dependent automatically enrolled in COBRA for dental and vision, even if they have enrolled in COBRA for the state's medical plan. See page 21 for more information.

Contact UBT at **800-228-5088** or **614-508-2255** or email to **customerservice@benefitstrust.org**.

Access your member-specific benefits at **benefitstrust.org.** Click MyUBT to register and create a password for a secure login.

- Check you plan coverages for dental, vision, life and legal
- Check what dependents you have covered
- Find out how much life insurance you have for you and your dependents

To access network providers you do not need to create a personal account. Link to all plan networks via the PLANS tab.

Find forms and booklets via the FORMS & INFO tab.

View Frequently Asked Questions via the FAQ tab.

DENTAL BENEFITS

UBT DENTAL PLAN

Your UBT Trustees have selected Delta Dental of Ohio as your dental carrier effective July 1, 2010.

The UBT Dental Plan covers diagnostic and preventative services at 100% and no annual deductible is required for Class 1 or 4 services. You must meet the annual deductible of $25 per person, for Class 2 and 3 services, before benefits are paid.

Benefits will be paid up to the maximum annual benefit amount of $1500 per person per plan year.

Out-of-pocket costs may vary depending on the provider you choose. You will be covered by one plan, but your savings are determined by the dentist you choose.

One plan, three levels of coverage

- **Delta Dental PPO** providers offer the highest level of savings and cannot balance-bill you for additional payment for the services you received. That means no additional out of pocket expenses.
- **Delta Dental Premier** providers are in the secondary network. While you receive a more modest savings compared to the PPO dentist, you will have many more dentists to choose from than the PPO. You cannot be balance-billed for the difference between the dental charge and the allowed amount.
- **Non-participating** providers will balance-bill you for any amount that exceeds Delta Dental's allowed amount. They may ask you to pay the full amount up front and may have you submit your claim information to receive reimbursement.

PLAN ADMINISTRATION

The UBT Dental Plan is administered by Delta Dental of Ohio, a Third Party Administrator (TPA) with two dental provider networks: the Delta Dental PPO and Delta Dental Premier. With two networks available the UBT Dental Plan offers access to more in-network providers and thus greater savings to its members.

The UBT DENTAL Plan also has an out of network benefit. So you can see any dentist you choose and the plan will pay, however benefits are better in one of Delta Dental's two networks.

For a summary of benefits and the percentages of dentists' fees the plan pays in the PPO, Premier or out of network, see the chart on pages 10 and 11. See Page 12 for plan payment examples by network.

You must meet a deductible of $25 per person each plan year before benefits are payable for restorative services, oral surgery, endodontic, periodontic and prosthodontic services (Class 2 and 3 services combined).

Finding a Participating Dentist

To find the names of participating dentists near you, call Delta Dental's customer service department toll-free at **877-334-5008**. The DASI (Delta's Automated Service Inquiry) system is available 24 hours a day, seven days a week, and can provide you with the names of participating dentists. You can also check the Delta Dental link under the PLANS tab, or go directly to **deltadentaloh.com**.

PRE-TREATMENT ESTIMATE

A pre-treatment estimate is recommended for services over $300. It outlines what the plan will pay, giving you an idea as to the portion of the cost that will be your responsibility. See page 13 for claims information.

NETWORK FEE

A discounted fee negotiated by Delta Dental for services from network providers.

UBT DENTAL PLAN

This chart presents a summary of benefits and reflects the amount that the plan pays for your treatment or services. Please read the sections that follow for details on plan benefits and limitations. Benefit Classes 2 and 3 are subject to the annual plan deductible of $25 per person. Benefit Classes 1 and 4 have no deductible.

	PPO Dentist	Premier Dentist	Non-participating Dentist*
Annual Maximum $1500 per person per benefit year	Plan Pays	Plan Pays	Plan Pays*
CLASS 1 SERVICES			
Diagnostic and Preventive Services			
Oral Exams twice per plan year	100%	100%	100%*
Cleanings (prophylaxes) twice per plan year	100%	100%	100%*
Full mouth x-rays once in any three year period	100%	100%	100%*
Bitewing X-rays twice per plan year	100%	100%	100%*
Topical fluoride treatment for age 18 and under or age 55 or older, twice per plan year	100%	100%	100%*
Space maintainers, age 18 and under, once per lifetime	100%	100%	100%*
Emergency palliative treatment (temporary pain relief)	100%	100%	100%*
Sealants for unblemished permanent molars for age 18 and under, once per tooth, per three year period	100%	100%	100%*
Brush biopsy	100%	100%	100%*
CLASS 2 SERVICES (annual $25 deductible applies)			
Restorative Services			
Filings	100%	65%	65%*
Routine extractions	100%	65%	65%*
Relining and rebasing of existing removable dentures, once in any three year period	100%	65%	65%*
Repair or re-cementing of crowns, inlays, onlays, dentures or bridgework	100%	65%	65%*
Oral Surgery			
Complex extractions or removal of tooth or root	100%	65%	65%*
General anesthesia when medically necessary in connection with a covered dental service	100%	65%	65%*
Antibiotic injections	100%	65%	65%*
Endodontic			
Root canal, pulp capping, pulpotomy or therapy for diseases of the soft tissue	100%	65%	65%*
Periodontics			
Treatment of diseases of the gums and tissue	100%	65%	65%*
Periodontal maintenance cleanings following some form of periodontal treatment	100%	65%	65%*

	PPO Dentist	Premier Dentist	Non-participating Dentist*
Annual Maximum $1500 per person per benefit year	Plan Pays	Plan Pays	Plan Pays*
CLASS 3 SERVICES (annual $25 deductible applies)			
Prosthodontics (crowns, implants, bridges, dentures)			
Installation of fixed bridgework	60%	50%	50%*
Installation of implants and implant related services, once per tooth in any five year period	60%	50%	50%*
Installation of a partial removable or full removable denture	60%	50%	50%*
Crowns, inlays, and onlays up to one such restoration to the same tooth surface, once in any five year period	60%	50%	50%*
Replacement of an existing removable denture or fixed bridgework. Must be due to the loss of one or more natural teeth after the existing denture was installed or if the existing denture or bridge-work is at least five years old and unserviceable	60%	50%	50%*
Replacement of an existing immediate temporary full denture by a new permanent full denture. Must be necessary because the existing denture cannot be made permanent and the permanent denture is installed with 12 months after the existing denture was installed.	60%	50%	50%*
Addition of teeth to an existing partial removable denture. Must be needed to replace one or more natural teeth removed after the existing denture was installed.	60%	50%	50%*
CLASS 4 SERVICES			
Orthodontia (children only)	**Lifetime Orthodontic Maximum $1500**		
Services for the treatment of irregularities of the teeth and their correction, including appliance therapy, so as to bring about proper occlusion. Dependent children are eligible until the end of the month in which the child reaches age 19 or 23 if a student.	50% up to $1,500**	50% up to $1,500**	50%* up to $1,500**

The Annual Maximum Payment per person, per benefit year is $1,500 for all services except Orthodontics.
The Annual $25 Deductible is for class 2 and class 3 services combined.
**The separate lifetime maximum payment for orthodontic services is $1,500 per person.
Orthodontic payment is based on the treatment plan submitted by the dentist including but not limited to the date of the banding or placement of the appliance, and the number of months of treatment. Payment begins once the bands or the appliance is placed and will continue on a monthly basis as long as you are eligible under the dental plan until the end of treatment or your $1,500 maximum has been met.
*The percentages in the "Nonparticipating Dentist' column will be paid based on Delta Dental's Allowed Amount for non-participating dentists for that service, not necessarily the amount the dentist bills. This could leave a balance due, which you are responsible for. See the example on page 12.

DENTAL BENEFIT INFORMATION

CONDITIONS FOR PROVIDING BENEFITS

Certain plan benefits, as explained in the next section, are payable according to important conditions described below.

ALTERNATE BENEFIT

Dental benefits will be based on the materials and method of treatment which cost the least and which, in the opinion of the claims administrator, generally meet accepted dental standards.

OVERPAYMENTS

If the plan pays more than it should for expenses incurred by you or your covered dependents, Delta Dental has the right to a refund from you. The refund amount will equal the difference between what was actually paid and what should have been paid. Instances where refunds may occur: when you fail to pay all or some of the expenses you're required to, or another party pays all or some of the expenses on your behalf.

PLAN LIMITS

Generally, plan benefits are limited by the frequency or benefit amount per plan year.

- Plan year July 1 to June 30
- Plan year benefit $1,500 per person
- Annual deductible applies to Class 2 and 3 services combined
- Full mouth x-rays have a 3 year frequency
- Class 3 appliances have a five year frequency limit
- Orthodontia has a separate once in a lifetime benefit; the lifetime maximum payment is $1,500

A full description is available online, or you can get a copy from the UBT.

EXAMPLE OF UBT DENTAL PLAN PAYMENT

	PPO Dentist	**Premier Dentist**	**Non-participating Dentist**
File claim and receive payment	The PPO Dentist	The Premier Dentist	You
What is the payment based on?	The billed fee or the amount in your dentist's local PPO Fee Schedule[1], whichever is less.	The billed fee or the Maximum Approved Fee[2], whichever is less.	The billed fee or the Non-participating Dentist Fee[3], whichever is less.
Payment example of a Class 2 dental benefit (assuming any applicable deductible has been met)	Billed Charges: $100.00 PPO Fee Schedule amount: $76.00 Delta Dental pays **100%** of the PPO fee schedule: $76.00 **Member pays: $0.00** *The PPO dentist cannot charge you the $24 difference between the PPO Fee Schedule amount and his/her fee.*	Billed Charges: $100.00 Maximum Approved Fee: $92.00 Delta Dental pays **65%** of the Maximum Approved Fee: $59.80 **Member pays: $32.20** *The Premier dentist cannot charge you the $8 difference between the Maximum Approved Fee and his/her fee.*	Billed Charges $100.00 Non-Par Dentist Fee amount: $88.00 Delta Dental pays **65%** of the Non-Participating Dentist Fee amount: $57.20 **Member pays: $42.80** *Because the dentist does not participate, you are responsible for the difference between Delta's payment and his/her fee.*

[1] A PPO Dentist is one that has agreed to the PPO Fee Schedule, which is lower than Maximum Approved Fee used for a dentist who participates in Delta Dental Premier.

[2] Maximum Approved Fee is the maximum amount approved for a specific procedure determined by Delta Dental in the Premier program.

[3] Non-participating Dentist Fee is the maximum fee allowed when the dentist does not participate.

CLAIMS

SEEKING A PRE-TREATMENT ESTIMATE (PRE-DETERMINATION)

You can find out what your plan pays before your dentist begins treatment. If a dental service is expected to be $300 or more and related to crowns, dentures, inlays, onlays, implants or periodontics, ask your dentist to file a pre-determination claim with Delta Dental. Using a claim form, the dentist will explain what work is to be done and what the cost will be (a pseudo claim). Delta dental will send you an Explanation of Benefits (EOB) and tell you what benefits are payable. If you need to file your own pre-determination claim, use the dental claim form available at **benefitstrust.org** under the Forms & Info Tab.

Do not use this process for emergency treatment, routine oral exams, x-rays, cleaning and scaling and fluoride treatments.

FILING A CLAIM

If you see a network provider, he or she will submit a claim for you.

If you see a provider who is not in the network, you must provide proof to the claims administrator (Delta Dental) no later than 12 months after the date of service to receive benefits. Dental claim forms are available online from UBT or Delta Dental. You and your dentist will need to answer all of the information requested. Either you or your dentist may file the claim with Delta Dental.

To determine what benefits are payable, Delta Dental may ask for x-rays and other diagnostic and evaluative materials. If these materials are not submitted, Delta Dental will determine benefits on the basis of information that is available.

Some dentists who do not participate in the Delta Dental network may require payment at the time of service; ask when you schedule your appointment. The Plan payment will be sent directly to you.

When filing a claim, the claim must include:

- patient's name and ID number
- service or supply and CDT code
- itemized charges
- date(s) of service
- dentist's name, tax ID number and address.

Send your completed claim form to:

Delta Dental
P.O. Box 9085
Farmington Hills, MI
48333-9085.

APPEALING A CLAIM DENIAL

If you believe your benefits were denied improperly and/or were medically necessary, you may informally appeal the decision by calling Delta at **877-334-5008** or mailing your inquiry, including a copy of your EOB and a description of the problem to:

Delta Dental at
P.O. Box 9085,
Farmington Hills, MI 48333-9085.

This process needs to be completed within 180 days of the notice of denial.

If you've gone though the steps above and are still dissatisfied with the plan payment, you may file a formal appeal in writing, including any additional information for Delta review, and send it to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, MI 48909-7916.

DENTAL EXCLUSIONS & LIMITS

Coverage is not provided for the following:

1. Services or supplies received before dental benefits are effective for a covered person.
2. Services not performed by a dentist, except for those services (cleaning and scaling of teeth and fluoride treatments) of a licensed dental hygienist which are supervised and billed by a dentist.
3. Cosmetic surgery, treatment or supplies, unless required for the treatment or correction of a congenital defect of a newborn dependent child.
4. Replacement of a lost, missing or stolen crown, bridge or denture.
5. Repair or replacement of an orthodontic appliance.
6. Services or supplies which are covered by any workers compensation law or occupational disease law.
7. Services or supplies which are covered by any employers liability law.
8. Services or supplies which any employer is required by law to furnish in whole or in part.
9. Services or supplies received through a medical department or similar facility, which is maintained by the covered person's employer.
10. Services or supplies received by a covered person for which no charge would have been made in the absence of dental benefits for that person.
11. Services or supplies for which a covered person is not required to pay.
12. Services or supplies that are deemed experimental in terms of generally accepted dental standards.
13. Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the benefits for the covered person are in effect.
14. Adjustment of a denture or a bridgework which is made within 6 months after installation by the same dentist who installed it.
15. Any duplicate appliance or prosthetic device.
16. Use of materials to prevent decay, other than fluorides for participants under 19 or over 55.
17. Use of a sealant material for treatment of the molar teeth for a participant over age 19, or for treatment of molar tooth more frequently than once every 36 months for dependent child under the age of 19.
18. Instruction for oral care such as hygiene or diet.
19. Periodontal splinting.
20. Services or supplies to the extent that benefits are otherwise provided under this plan or under any other plan which the employer (or an affiliate) contributes to or sponsors.
21. Myofunctional therapy.
22. Charges for broken appointments.
23. Charges by the dentist for completing dental forms.
24. Sterilization supplies.
25. Services or supplies furnished by a family member.
26. Treatment of temporomandibular joint (TMJ) disorders.
27. Consultations when performed in conjunction with related treatments.
28. Occlusal guards for bruxism.
29. Services not rendered.
30. Osseous surgery.
31. Expenses incurred by a covered person after coverage ends, even if the claims administrator has approved a pre-treatment plan, except for the following:

- A prosthetic device if the dentist prepared the abutment teeth and made impressions while coverage was in effect and the device is installed within 90 days after the date benefits end.
- A crown, inlay or onlay including cast post and core and crown repair if the dentist prepared the tooth including cast post and core and crown repair while coverage was in effect and installation is completed within 90 days after benefits end.
- Root canal therapy including apexification if the dentist opened the tooth while coverage was in effect and treatment is completed within 90 days after the date benefits end.

VISION BENEFITS

HOW THE VISION PLANS WORK

UBT offers you and your family high-quality vision plans intended to meet your needs. When you enroll, you can choose from either of UBT's vision plans (if you're eligible). There are no restrictions on your plan choices and you pay no premiums. Both plans are available to you and both plans cover a wide range of services as shown on the following pages.

Regardless of where you live or work, you may choose from either the:

- Vision Service Plan (VSP) Choice Network *Group Number 12022914* or
- EyeMed Vision Care Plan (EyeMed). Select Network *Group Number 9674813*

Choose from either of the UBT plans, remember, network availability varies by location and is an important feature of the plans.

VISION SERVICE PLAN (VSP) CHOICE NETWORK

The Vision Service Plan (VSP) has a national, independent network of providers who provide high-quality eye care and materials to members. The network is spread throughout Ohio and has participating providers (over 1,000 currently) in all 88 counties.

This plan also allows you freedom of choice: you may visit the licensed provider of your choice. However, if you visit a provider that is not in the Choice Network, you will receive a lower level of benefits than with VSP network providers.

Call VSP to help you choose a network provider at **800-877-7195**. Or, you can visit **benefitstrust.org** under the PLANS tab to link to the Choice Network directory information.

EYEMED VISION CARE PLAN (EYEMED) SELECT NETWORK

EyeMed provides high-quality eye care and materials through a national network of independent providers, well known retailers: Target, Sears, LensCrafters, *participating* Pearl Vision Centers, JC Penney stores and online services at both **glasses.com** and **contactsdirect.com**.

This plan also allows you freedom of choice: you may visit the licensed provider of your choice. However, if you visit a provider that is not in the Select Network, you will receive a lower level of benefits than with EyeMed network providers.

Call EyeMed to help you choose a network provider at **866-723-0514**. Or, you can visit **benefitstrust.org** the PLANS tab to link to the Select Network directory information.

FILING AN OUT-OF-NETWORK CLAIM

In both plans, all network providers will submit claims for you and your family. If services are provided by an out-of- network provider, he or she may or may not file your claim. Should you need to file a claim, out of network claim forms are available at **benefitstrust.org** under the Forms & Info Tab.

COMPARE THE VISION PLANS

	Vision Service Plan (VSP)		EyeMed Managed Vision Plan	
	Network	Out-of-network	Network	Out-of-network
Standard Exam				
Spectacle Exam	you pay only $10	plan pays up to $25 you pay remainder	you pay only $5	plan pays up to $25 you pay remainder
Contact Lens Exam	you pay $10 plus a fitting fee	plan pays up to $25 you pay remainder	you pay $5 plus a fitting fee	plan pays up to $25 you pay remainder
Exam available every 12 months, all ages.				
Materials				
Single Vision Lenses	you pay only $15	plan pays up to $25	plan pays in full	plan pays up to $25
Bifocal Lenses	you pay only $15	plan pays up to $35	plan pays in full	plan pays up to $35
Trifocal Lenses	you pay only $15	plan pays up to $52	plan pays in full	plan pays up to $52
Lenticular Lenses	you pay only $15	plan pays up to $62	plan pays in full	plan pays up to $62
Frames – ask at purchase to see frames fully overed	plan pays up to $150 retail	plan pays up to $18	plan pays up to $150 retail	plan pays up to $18
Polycarbonate Lens Option	plan pays in full	you pay full cost	plan pays in full	you pay full cost
Progressive Lens Option	plan pays in full	plan pays up to $52	$0/$20/$30/$45 or 80% of charge less $120 allowance (depending on lens)	pays up to $55
Contact Lenses Elective	plan pays up to $125	plan pays up to $105	plan pays up to $125	pays up to $105
Contact Lenses Medically Necessary	you pay only $15	plan pays up to $210	plan pays in full	plan pays up to $210
Benefits for one set of materials (either spectacle lenses and frames or contact lenses) are available once every 12 months. Single, Bifocal, Trifocal, Progressive and Lenticular lenses in chart reflect plastic lenses only.*				

Benefits are available every 12 months, all ages.

Exam and lens benefits may be available sooner in case of a sizeable prescription change. See the section on Early Coverage.

After you have used the benefits provided above, **discounts for professional services and materials by network providers may be available.** See the section Additional Discounts on page 17.

Covered lenses include only options specifically listed above; options such as high index or photochromic are not covered by the plan. A polycarbonate lens option is available to you at no cost, in-network only.

The plan is intended to cover visual needs rather than cosmetic materials. See the section on Cosmetic Options. The patient will pay the full cost of some options; ask your provider for the full cost ahead of time.

Benefits for lenses and frames include such professional services as are necessary to prescribe and order lenses, assist in the selection of frames, verify the accuracy of finished lenses, properly fit and adjust frames, subsequent adjustments to maintain frame comfort and efficiency and progress or follow-up work as necessary. Standard exam benefits are also payable as shown in the chart above.

Medically necessary contact lenses will be provided with prior authorization only under one of the following circumstances: after cataract surgery, to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, and with certain conditions of Anisometropia and Keratoconus.

**For glass lenses:*
VSP - same as in chart
EyeMed - 20% off

EARLY COVERAGE

The claims administrators may authorize payment for additional exam and lenses if the new prescription:

- differs from the original by at least a .50 diopter sphere or cylinder change or a change in the axis of 20 degrees or more and
- improves visual acuity by at least one line on the standard chart or is medically necessary.

COSMETIC OPTIONS

The plans are intended to cover visual needs rather than cosmetic materials. When a covered person opts for extras, such as those listed below, the plan will pay the basic cost of the allowed lenses and the covered person will pay the additional costs for the options:

- Contact lenses (except as noted earlier)
- Oversize lenses (considered cosmetic by VSP only; EyeMed covers)
- Photochromic lenses (tinted lenses except pink #1 and pink #2)
- Coating and laminating of the lenses
- Frames that exceed plan allowance
- Cosmetic lenses
- Optional cosmetic processes or
- UV (ultraviolet) protected lenses.

Discounts may be available to plan members on some of these features. See the section below on Additional Discounts.

LOW VISION BENEFITS

Subject to prior approval by the claims administrators, low vision benefits are available to covered persons who have severe visual problems that are not correctable with regular lenses. This means that vision cannot be corrected to 20/70 with lenses, but sight is better than 20/200 (legally blind). The services listed in the chart below are covered and limited to $1,000 every two years.

ADDITIONAL DISCOUNTS

Discount programs offer you a way to obtain lower costs on eye care after you have used your UBT benefits coverage. Both EyeMed and VSP offer discount programs on materials when you use in-network providers.

Both EyeMed and VSP offer the following discount which may be used in conjunction with your UBT benefits:

- 20% off the frame cost over the plan's frame allowance.

Other discounts vary between the plans.

In some circumstances, certain brands may not be eligible for discounts listed in this booklet. Ask your provider at the time of purchase.

Vision Discount Chart		
	VSP	EyeMed
Additional pairs of glasses	20% off	40% off or promotional offer, which-ever is less
Additional lens options	Preferred pricing	20% off
Contact lens exam and fitting	15% off professional fees	10% off premium fitting. Standard lens fitting up to $40.

A WORD ABOUT DISCOUNTS

We encourage you to be a wise consumer. Your benefit plan will usually give you the best benefit, especially if you are using in-network providers. However, you may occasionally see advertisements for special offers, sales, rebates, etc. Our benefits are designed to stand alone. In some cases, you may be able to apply both deals; however, in most instances you will need to choose your benefit plan or the coupon savings. Ask your provider for more information and read the fine print of the coupon/offer if you are uncertain.

	Vision Service Plan (VSP)		EyeMed Vision Care Plan (EyeMed)	
	Network	**Out-of-network**	**Network**	**Out-of-network**
Low Vision Benefits				
Supplemental testing	plan pays in full	plan pays at network rate	plan pays in full	plan pays at network rate
Supplemental care	plan pays 75%, you pay 25%	plan pays 75% of network rate, you pay remainder	plan pays 75%, you pay 25%	plan pays up to $25 you pay remainder

LASER SURGERY

Both VSP and EyeMed offer **discount** programs for laser surgery with network providers. Discounts mean that the fees you would ordinarily pay will be reduced by 15–25%. Learn more about laser vision correction and follow the procedures for your plan if you are interested.

For VSP's laser partner:

Call your VSP doctor to see if he or she is participating in the program. To find a doctor, call **800-877-7195** or go to the VSP website. You may want to contact VSP's laser care support line at **888-354-4434**.

Schedule a free screening and consultation about laser vision correction with your VSP doctor. Your doctor can also coordinate with the VSP-approved laser surgeons and centers.

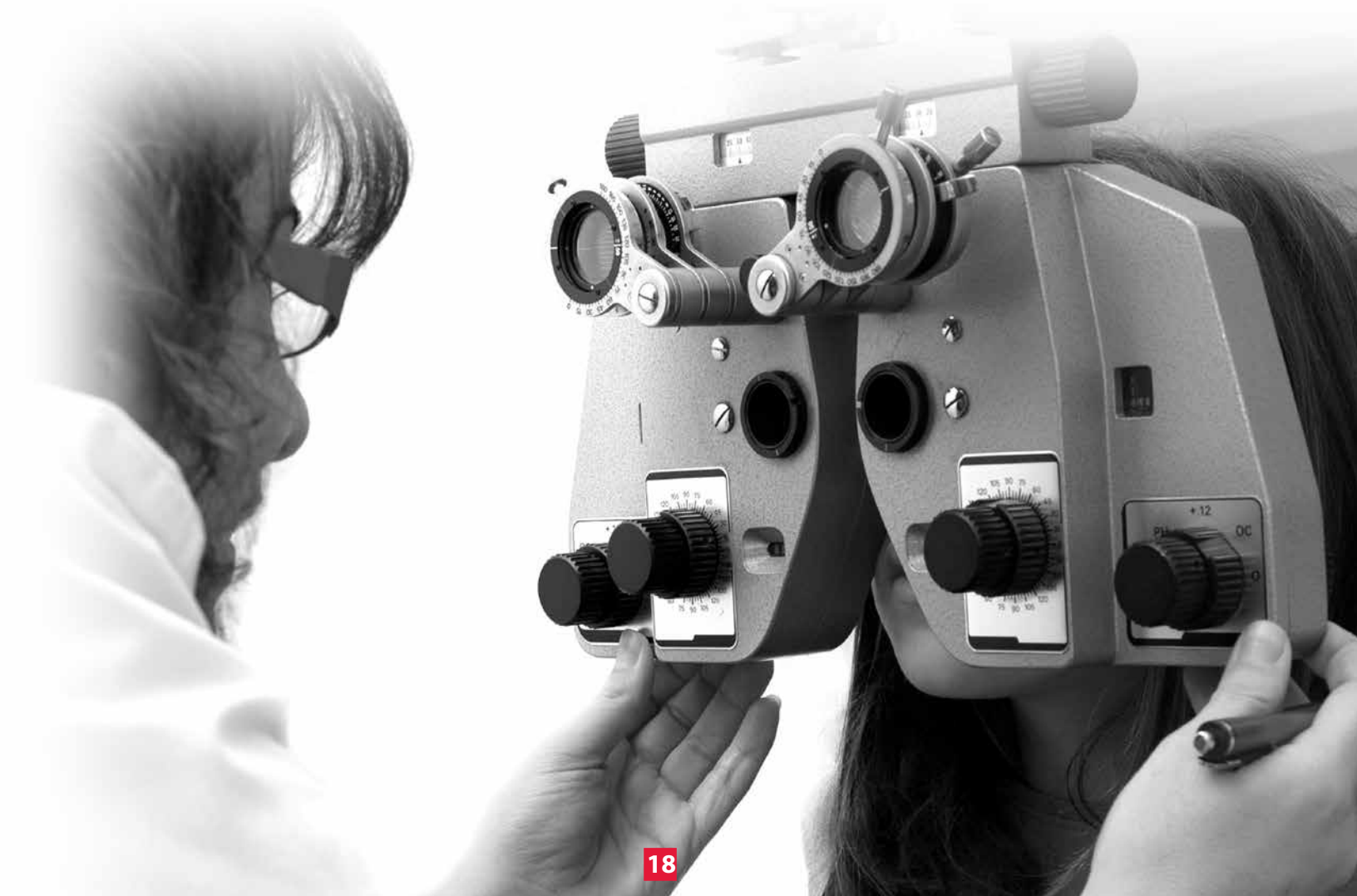
Your post-operative care will be coordinated between your VSP doctor and the laser surgeon.

For EyeMed's laser partner:

Call **877-552-7376** for information. The customer service representative can tell you where the closest network laser surgery center is located.

Schedule a free screening and consultation about laser vision correction with the laser doctor.

Your pre- and post-operative care will take place at the surgery center.



VISION EXCLUSIONS & LIMITS

Coverage is not provided for the following:

- Services or supplies received before vision benefits are effective for a covered person.
- Services performed by a non-licensed professional.
- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a .50 diopter power); or two pairs of glasses in lieu of bifocals.
- Non-prescription sunglasses.
- Replacement of lenses and frames furnished under this plan that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Any eye examination or any corrective eyewear required by an employer as a condition of employment.
- Services or supplies which are covered by any workers' compensation law or occupational disease law.
- Services or supplies which are covered by any employers' liability law.
- Services or supplies which any employer is required by law to furnish in whole or in part.
- Services or supplies received through a medical department or similar facility, which is maintained by the covered person's employer.
- Services or supplies received by a covered person for which no charge would have been made in the absence of vision benefits for that person.
- Services or supplies for which a covered person is not required to pay.
- Services or supplies that are deemed experimental in terms of generally accepted vision standards.
- Services or supplies received as a result of disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the benefits for the covered person are in effect.
- Services or supplies to the extent that benefits are otherwise provided under this plan or under any other plan to which the employer (or an affiliate) contributes or sponsors.
- Charges for broken appointments.
- Charges by the provider for completing vision forms.
- Services or supplies furnished by a family member.
- Consultations or exams, other than routine exams, when performed in conjunction with related treatments.

APPEALING A CLAIM DENIAL

If you believe your benefits were denied improperly, you must file a written appeal for the unpaid amount within 60 days after you receive notice of denial of the claim. An appeal form can be obtained from your plan. Specify the reason you believe the claim was improperly denied and any other data that may be pertinent and send it to the appropriate claims administrator at the address shown.

COORDINATING DENTAL & VISION BENEFITS

COORDINATION RULES

If both you and your spouse work, you and/or your family members may be covered by more than one dental or vision plan. Most plans contain a coordination of benefits (COB) clause to prevent duplication of benefits.

Under a COB provision, the plan that pays benefits first is the primary plan. The secondary plan pays benefits after the primary plan. If the other plan pays first, UBT's plan coordinates benefits with payments made by the other plan. UBT's plan will pay the difference between the amount this plan would normally pay and the amount the other plan has paid. This approach means that your combined benefits (those UBT's plan pays plus what the other plan pays) are not more than charged.

DENTAL

Here's a dental example that assumes the deductible has already been met for both plans.

A dental expense of $100 would be paid at 100% ($100) if UBT's plan was primary. If another plan paid $65 of the dental expense (as primary), UBT (as secondary) would make a contribution to the dental expense in the amount of $35. If another plan has denied benefits for expenses that are covered dental expenses under UBT's plan, UBT's plan will calculate benefits as if it were primary.

VISION

VSP

When VSP pays as secondary, the member will receive a specified allowance for each service (exam, lenses, frame and contacts) that will pay up to, but no more than, the billed amount.

EyeMed

There is no COB with the EyeMed Vison Plan.

ORDER OF BENEFITS

When more than one plan covers the person, there are rules that govern which plan pays benefits when expenses are incurred. Rules 3 and 4 have not been adopted by all other plans and if not, they do not apply.

1. The plan that covers a person as an employee (or retiree) determines benefits before the plan that covers a person as a dependent, except for Medicare. If the person is covered as an employee or a dependent, Medicare is secondary.
2. For dependent children, the primary plan of the parent whose birthday comes first during the calendar year will be primary for the children:

- if the parents are married
- if the parents are not separated (whether or not they ever have been married) or
- if a court decree awards joint custody without specifying that one party is responsible for providing healthcare coverage.

If both parents have the same date of birth (except for year of birth), the plan that covered the parent for the longer time is primary for the children. If the court decree states that one parent is responsible for healthcare coverage and that plan has knowledge of those terms, the plan is primary.

If the parents are not married or are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

- the plan of the custodial parent
- the plan of the spouse of the custodial parent
- the plan of the non-custodial parent, and then
- the plan of the spouse of the non-custodial parent.

3. The plan that covered a person as an active employee (or that employee's dependent) is primary to a plan that covered a person as a laid-off or retired employee (or that employee's dependent).
4. The plan that covers a person as an active employee (or as that employee's dependent) is primary to a plan that covers that person under right of continuation in federal or state law.
5. If none of the above rules (1-4) determine the order of benefits, the plan that has covered the employee for the longer time determines benefits before the plan that covered that person for the shorter time.

RIGHT TO INFORMATION

Certain facts are needed to apply these Coordination of Benefits rules. Delta Dental has the right as plan administrator to decide which facts they need, get facts from or give facts to any other organization or person without consent. To obtain benefits available, each person claiming benefits under this plan must provide facts needed by Delta Dental to pay the claim.

RIGHT OF RECOVERY

If the amount of the payments made by Delta Dental is more than should have been paid under this Coordination of Benefits provision, Delta Dental may recover the excess from one or more of the following: the person paid, insurance companies or other organization. The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services.

CONTINUING YOUR BENEFITS (COBRA)

If your dental and vision coverage and/or your dependent's dental and vision coverage ends, you may extend it temporarily under COBRA. COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a federal law through which group rates are extended to employees and/or their dependents who would otherwise lose their coverage. You are responsible for the full cost of coverage and an administrative fee (up to 2% of the coverage's cost). If you fail to make a COBRA premium payment, you will lose coverage under this plan permanently.

UBT will provide you with COBRA information when you lose coverage; however, you are responsible for notifying UBT if you want COBRA coverage for a dependent. You must provide notice within 60 days of when the dependent's coverage would otherwise end. In either case you, or your dependent, will then receive benefits continuation enrollment information directly from UBT.

At no time is your overage dependent automatically enrolled in COBRA for dental and vision, even if they have enrolled in COBRA for the state's medical plan.
For more information contact UBT at **800-228-5088** or **614-508-2255**.

Dental and vision benefits are not affected by 2010 Health Care Reform Act. As a result, dependents over age 18 (or 23 if student) cannot continue on your dental and vision coverage even though they might be covered under your health plan.

Dental and vision coverage for your overage dependent may be available through COBRA. Dependents over age 18 (or 23 if student) may be eligible for up to 36 months of coverage through the COBRA program.

BASIC LIFE

ELIGIBILITY

Employees

Members of participating Unions are eligible for basic life insurance benefits the first of the month following one year of continuous State Service automatically at no cost. To be eligible, you must first be a full or part-time permanent employee and a member of:

- OCSEA/AFSCME – Units 3-9, 13, 14, 45, 50, 55
- District 1199/SEIU – Units 11, 12
- OSTA – Units 1, 15
- FOP/OLC – Units 2, 46, 48
- SCOPE/OEA – Unit 10 or
- CWA – Unit 40.

Established term employees are eligible unless excluded by an agency-specific agreement. See your HR Representative for details.

Accidental death and dismemberment benefit coverage varies by Union and unit:

- Occupational-only Accidental Death and Dismemberment benefits are available for those represented by OCSEA, SCOPE/OEA, FOP/OLC unit 48, CWA.
- 24-Hour Accidental Death and Dismemberment benefits are available for those represented by District 1199/SEIU, OSTA, FOP/OLC unit 2 and 46.

BENEFITS

Your basic life insurance benefit equals one times your basic annual earnings (rounded to the next higher thousand) up to a maximum of $150,000; your benefit will not be less than $10,000 (the minimum).

Basic annual earnings include your regular payment from the State of Ohio during a 12-month period, but not any commissions, bonuses, overtime or fringe benefits. Your basic annual earnings for this purpose will be your hourly base rate of pay times 2,080 if you are considered permanent full time or 1,040 if you are considered permanent part time.

Your basic life insurance will increase automatically as your base rate of pay increases.

ENROLLMENT

Effective dates

For members who are actively at work, coverage automatically will be effective on the first day of the month following one year of continuous State service. If you're not actively at work on the date your coverage would otherwise begin, your coverage will take effect on the first day of the month following the date on which you return to work.

COST OF COVERAGE

Basic life insurance coverage and accidental death benefits are provided at no cost to you.

YOUR COVERAGE

When you are on leave

In some cases your basic life insurance coverage and accidental death benefits may continue when you are not actively at work for the length of your authorized State leave. See your HR Representative for details on continuation.

When your coverage ends

Your basic life insurance and accidental death benefits end on the last day of the calendar month in which you no longer meet eligibility requirements. However in certain circumstances, you may convert or port your coverage. Please see information on page 26 for converting or porting your basic life plan.

Dependents

No basic life insurance benefits are available to dependents.

ACCELERATED DEATH BENEFITS

If you become terminally ill while covered by this basic life insurance, you may elect to receive the value of your benefits before your death. You are eligible for accelerated death benefits if you have been diagnosed with a terminal illness and you have less than 12 months to live.

You can request up to 100% of your basic life policy amount, not to exceed $500,000.

You may elect to receive a lump sum or payment in twelve equal monthly installments; either payment option is subject to a transaction fee of up to $150. If you select the lump sum option, your payments will be discounted by Prudential at a rate equal to the yield of 90-day Treasury Bills on the day they receive proof that you are terminally ill. Contact Prudential using the information on the back cover of this booklet to inquire about the exact amount of accelerated death benefits available to you.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The Accidental Death & Dismemberment benefit is part of your basic life insurance policy and coverage varies by Union and unit. See below to determine which coverage information pertains to you.

OCCUPATIONAL-ONLY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Benefits are available to members of OCSEA, SCOPE/OEA, FOP/OLC unit 48 and CWA.

If you sustain an injury while on the job and die within 365 days as a result of the injury, your basic life insurance will be doubled up to the maximum listed on page 22, "Benefits", not to exceed $300,000.

Example: If your basic life insurance amount is $28,000 and your death meets the above listed criteria, your beneficiary would receive a total benefit of $56,000.

In addition to loss of life benefits, dismemberment benefits including loss of sight, hand or foot, speech, hearing, thumb and index finder of the same hand and Quadriplegia, Paraplegia or Hemiplegia are covered benefits. Please refer to your Prudential booklet/certificate as the amount payable in this situation depends on the type of loss.

24 HOUR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Benefits are available to members of District 1199/SEIU, OSTA, and FOP/OLC units 2 and 46.

If you sustain an injury and die within 365 days as a result of the injury, your basic life insurance will be doubled up to the maximum listed on page 22, "Benefits", not to exceed $300,000.

Example: If your basic life insurance amount is $28,000 and your death meets the above listed criteria, your beneficiary would receive a total benefit of $56,000.

In addition to loss of life benefits, dismemberment benefits including loss of sight, hand or foot, speech, hearing, thumb and index finder of the same hand and Quadriplegia, Paraplegia or Hemiplegia are covered losses. Please refer to your Prudential booklet/certificate as the amount payable in this situation depends on the type of loss.

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Benefits are available to members of OCSEA, SCOPE/OEA, FOP/OLC units 2, 46, and 48, CWA, District 1199/SEIU, and OSTA.

Beneficiaries will receive additional proceeds when:

- Loss of life occurs as a result of an accident in a four wheel vehicle when using a seat belt; $10,000 or 10% of the amount of insurance, whichever is less.
- Loss of life occurs as a result of an accident in a four wheel vehicle equipped with a Supplemental Restraint System; $10,000 or 10% of the amount of insurance, whichever is less.
- Loss of life or dismemberment occurs due to felonious assault; five percent (5%) of the amount of insurance.
- A member passes, the spouse is eligible for tuition reimbursement within 30 months of the death equal to: actual tuition, 1% of the amount of AD&D insurance or $2,500, whichever is less.
- A member passes, tuition reimbursement is available for dependent children provided the child enrolls full time in college or trade school within 365 days of the death equal to: actual tuition, 1% of the amount of AD&D insurance or $2,500, whichever is less. Payable up to four (4) years, but not beyond age 23.
- A member passes, daycare expense reimbursement is available for dependent children if enrolled at a licensed facility with 90 days of the death equal to: actual cost, 1% of the amount of AD&D insurance or $2,000, whichever is less. Payable annually for up to four (4) consecutive years, but not beyond age 13.

Refer to page 24 for limitations and exclusion and your Prudential booklet/certificate for additional details.

ACCIDENTAL DEATH AND DISMEMBERMENT EXCLUSIONS & LIMITS

Regardless of unit or Union, no accidental death coverage is provided for losses caused by:

- Suicide or attempted suicide, while sane or insane.
- Intentionally self-inflicted injuries or any attempt to inflict such injuries.
- Sickness, whether your death results directly or indirectly from the sickness.
- Medical or surgical treatment of sickness, whether your death results directly or indirectly from the treatment.
- Any infection, but not a:

1. pyogenic infection resulting from an accidental cut or wound or
2. bacterial infection resulting from accidental ingestion of a contaminated substance.

- War, or any act of war, declared or undeclared, including resistance to armed aggression.
- Accident that occurs while you are serving on full-time active duty in any armed forces (service in the reserves or training for National Guard duty is covered and not part of this exclusion).
- Travel or flight in any vehicle used for aerial navigation, which includes getting in, out, on or off any such vehicle. This exclusion does not apply if you are in the course of any work for wage or profit from the State of Ohio (your employer). "Vehicle" in this exclusion encompasses all aircraft, including but not limited to those not intended or licensed for flight, and any aircraft owned, leased or operated by the State of Ohio (your employer) unless you are in the course of any work for wage or profit from the State of Ohio (your employer).
- Participation in these hazardous sports, unless you are in the course of any work for wage or profit from the State of Ohio (your employer): SCUBA diving, bungee jumping, skydiving, parachuting, hang gliding or ballooning.
- Commission of or attempt to commit a felony.
- Being legally intoxicated from the use of alcohol while driving a motor vehicle.
- Taking drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens, unless prescribed or administered by a doctor.

See page 23 for seatbelt and supplemental restraint additional benefits.

Accidental Death Benefit coverage is not portable or convertible.

BENEFICIARIES & CLAIMS

BENEFICIARIES

A beneficiary is a person chosen by you to receive your basic life insurance benefits upon your death. You have the right to choose a beneficiary and to change that beneficiary at any time without the consent of the present beneficiary. If you participate in the supplemental life insurance program also, you may have separate beneficiary designations for basic and supplemental life or the same beneficiary for both. See the chart on this page for some common beneficiary designation examples.

Beneficiary designations can be made or changed any time online by linking to Prudential from **benefitstrust.org** under the Basic Life tab or with the scannable paper form available under the Forms & Info Tab. Whether you designate online or by paper, your designation will be viewable online. You'll need to register at the Prudential site and choose a secure password to view your designation.

When you choose to designate your beneficiary online, your designation is viewable immediately. If you use the scannable paper form it will be viewable online once Prudential has received your completed form. Be sure to sign your form before mailing it to the address on the form.

If no beneficiary designation is made under the group policy (or if there is no surviving designated beneficiary and the beneficiary designation does not indicate how the insurance proceeds are to be distributed), the settlement will be made in this order of survivorship: spouse, children, parents, brothers and sisters; and if there are no such relatives surviving the insured, settlement will be made to the estate.

If none of the examples above are suitable, explain what you want on the Prudential beneficiary form or attach a note.

To designate	
One person	Write on the form the name and relationship in the space provided. If the beneficiary is not related to you, show the relationship as "Friend."
Your estate	Estate
Two persons	John J. Jones, father and Mary R. Jones, mother
Three persons or more	James O. Jones, brother; Peter I. Jones, brother; and Martha Jones, sister
Unnamed children	My children living at my death from my marriage to Lois P. Jones
One contingent beneficiary	Lois P. Jones, wife, if living; otherwise Herbert I. Jones, son
More than one contingent beneficiary	Lois P. Jones, wife, if living; otherwise Herbert I. Jones, son, Alice B. Jones, daughter and Ann Y. Jones, daughter
Unnamed children as contingent beneficiaries	Lois P. Jones, wife, if living; otherwise children living at my death from my marriage to said wife

CLAIMS

Benefits are paid to the beneficiary (beneficiaries) on file with Prudential. To file a death or accident claim, call Prudential for information from 7:00 a.m. - 8:00 p.m. Eastern Standard Time (Monday – Friday) at their toll free number, **844-533-4UBT (4828)** or send a copy of the death certificate directly to Prudential to begin the claims filing process.

Claim filing address

The Prudential Insurance Company of America
Life Claims Supervisor
P.O. Box 8517
Philadelphia, PA 19176-9802

WHEN BASIC LIFE COVERAGE ENDS

Basic Life Coverage ends the last day of the month in which your employment with the State of Ohio ends.

PORTABILITY AND CONVERSION

When your employment with the State ends for any reason, you have the option to port or convert your basic life insurance. Prudential will contact you within 31 days of you leaving State employment with information about the portability and conversion option, including the associated cost. **Portability and conversion are optional, and thus not automatic.**

WHAT DOES PORTABILITY AND CONVERSION MEAN?

- Porting means to continue your basic life insurance as **term insurance** after you leave State service.
- Conversion means to convert your basic life insurance to a **whole life policy** after you leave State service.
- When you port or convert your coverage, the terms and conditions of the contract may differ from your current group coverage in terms of benefits and cost.

WHAT ARE THE ADVANTAGES OF PORTABILITY AND CONVERSION?

- No interruption in your insurance coverage after your employment ends.
- Portability rates may be lower than the conversion rates and rates you might find on your own.
- No proof of good health is required.

WHOSE COVERAGE IS ELIGIBLE FOR PORTABILITY OR CONVERSION?

- The members' basic life insurance as long as the member is under the age of 80;
- All members leaving state service, including retiring and disabled members are eligible for portability or conversion.

COVERAGE AMOUNTS

You may generally choose a coverage amount equal to or less than the current Basic Life Insurance Benefit amount.

COST OF COVERAGE

Please call Prudential at **844-533-4UBT (4828)** to confirm the cost for porting or converting your life insurance coverage. Portability and conversion rates are not guaranteed and are subject to change.

The portability and conversion plans are administered through an insurance contract between you (the member) and The Prudential Life Insurance Company of America.

While the Trust or your former HR Representative can attempt to assist you with questions, in most cases it is better to contact Prudential directly once you have ported or converted your coverage.

ADMINISTRATION

ALL PLANS

Plan sponsor

Union Benefits Trust (UBT)
390 Worthington Road, Suite B
Westerville, Ohio 43082-8332
614-508-2255

Trustees

Seven representatives from OCSEA/AFSCME Local 11, one each from District 1199/SEIU, OSTA, FOP/OLC, SCOPE/OEA, and one representative appointed by the State.

You pay no premium for dental, vision and basic life.

How the plans are funded

Plan benefits are funded directly and indirectly by funds provided to the Union Benefits Trust by the State of Ohio through a collective bargaining agreement with the Ohio Civil Service Employees Association, AFSCME Local 11, AFL-CIO and other participating Unions.

97% of every dollar pays directly for member benefits.

Plan year

July 1 – June 30

Plan changes or termination

UBT expects to continue the dental, vision and basic life/accidental plans and other benefit plans. However, it reserves the right to change or discontinue any portion of the benefits described in this plan booklet.

DENTAL PLAN

Plan names and type

Union Benefits Trust
Self-insured dental plans:
Delta Dental of Ohio

How the plan is administered

Through an administrative services agreement with Delta Dental of Ohio.

VISION PLAN

Plan names and types

Union Benefits Trust
Self-insured vision plans: Vision Service Plan, EyeMed Vision Care Plan

How the plans are administered

Through administrative services agreements with Vision Service Plan and EyeMed Vision Care.

BASIC LIFE/ ACCIDENTAL DEATH

Plan name and type

Union Benefits Trust Insured Life Insurance Plan

How the plan is administered

Through an insurance contract and an administrative services agreement with The Prudential Life Insurance Company of America.

HIPAA

A federal law, commonly known as HIPAA (the Health Insurance Portability and Accountability Act of 1996), governs the use and disclosure of health information. Trust benefits presently are provided through insurance contracts or administrative service agreements with business associates; and, other than summary and enrollment information, UBT and its staff, and its Board of Trustees, presently do not systematically create, maintain, or receive protected health information ("PHI") as defined by HIPAA. To the extent that HIPAA's privacy rules may be applicable, the Trust will comply with such rules, and it has required its business associates that create, maintain, or receive PHI to observe HIPAA's privacy rules. If you believe that your rights under HIPAA have been violated, you have a right to file a complaint with UBT or with the Secretary of the U.S. Department of Health and Human Services. If you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, you may contact the Director of UBT.

Contacts

For general information & forms

UBT customer service

800-228-5088 • 614-508-2255

benefitstrust.org

Dental plans

For benefits, claims, network information and provider listing

Delta Dental of Ohio
877-334-5008
Group number 1009

Vision plans

For benefits, claims and discount (except laser) information

VSP **800-877-7195** *Group number 12022914*
EyeMed **866-723-0514** *Group number 9674813*

For network provider information

VSP **800-877-7195**
EyeMed **866-723-0514**

Laser discount program

VSP laser partner **888-354-4434**
EyeMed laser partner **877-552-7376**

Basic life/accidental death

For questions about death claims, accident claims, accelerated death benefits or coverage amounts

844-533-4UBT (4828)
Prudential Group number 01049

For all things UBT, or to link to all vendor's websites, visit benefitstrust.org.

Revised 10/2016