

The State of Ohio provides you with quality, affordable and competitive health care benefits as a part of your total compensation package. You have the flexibility to change your election to best fit your individual or family needs during the spring open enrollment period.

Each state employee has a choice of providers, which is based on where you live and work. The five current state health care providers include:

- [Aetna](#)
- [Ohio Med](#)
- [Paramount](#)
- [The Health Plan](#)
- [UnitedHealthcare](#)

Click the links below to access the information you need quickly.

[Enrollment](#)

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Comparing Costs of Medical Plan Providers (Click to view the links below)

The following links are effective through June 30, 2010

[Comparing the Cost of Your Medical Plan Options](#)

[Medical Plan Coverage Differences](#)

The following links are effective July 1, 2010

[Full-time Employee Deductions](#)

[Part-time Employee Deductions](#)

Medical Plan Coverage Differences

Out-of-Pocket Costs of Your Medical Plan Options

In-Network Core Benefits for All Medical Plans

What's Covered?

- Ambulance Service
- Chiropractic Services
- Diabetic Supplies
- Dietician Services
- Durable Medical Equipment
- Emergency Room
- Exams & Screenings
- Hearing Loss
- Home Health Care
- Hospice Services
- Immunizations
- Infertility Testing
- Inpatient and Outpatient Services
- Maternity - Delivery
- Maternity - Prenatal Care
- Mental Health and Substance Abuse
- Physical, Occupational and Speech Therapy
- Prescription Medications
- Prostheses
- Radiological Services
- Routine Tests
- Skilled Nursing Facility
- Urgent Care
- Well Child Care

Full-time vs. Part-Time

Full-time employees pay 15 percent of the premium as established by the state.

The percentage that part-time employees pay toward their premium is based on the average hours worked. Average hours in active pay status shall be calculated semi-annually on the basis of 13 pay periods, which start with the pay period that includes January 1 or July 1, respectively.

<u>Hours per bi-weekly pay period</u>	<u>Percent of Premium You Pay</u>
Less than 40	100%
40-59	50%
60-79	25%
80+	15%

PPO vs. HMO

What's the difference?

As a state employee, you have the option to select a Preferred Provider Organization (PPO) or a Health Maintenance Organization (HMO). You may select an HMO if it serves the ZIP code(s) in which you live or work. The fundamental difference between the two is that a PPO provides out-of-network coverage while an HMO does not.

For example: If you needed to see a doctor outside of your health care provider's network, you would receive a percentage of coverage if you were enrolled in a PPO, whereas if you were enrolled in an HMO, you would receive no coverage, except for emergency care.

Eligibility

Employee Eligibility

You are eligible for health care benefits if you are a permanent full-time or permanent part-time employee, which includes established-term regular, established-term irregular, a judge or other elected or appointed official.

State of Ohio employee health plans do not contain pre-existing condition exclusions; therefore, coverage is available to you and your eligible dependents regardless of current health or health history.

Employees classified as student help or college interns, or whose appointments are temporary, seasonal, interim or intermittent are not eligible for health coverage.

Married State Employees

When a husband and wife are both employed by the state, both employees cannot carry family coverage for medical, dental or vision. You have the following options:

Both may carry single coverage;

Both may be covered by one family plan; or

One employee may carry family coverage and the other single, but the spouse with single coverage may not be listed as a dependent under the family plan.

Employees NOT Eligible for Coverage

Full-time temporary, appointment types 2, 3, 5

Part-time seasonal, appointment type 6

Intermittent, appointment type 7

Full-time interim internal, appointment type 11, unless eligible prior to interim appointment

Part-time interim internal, appointment types 13

Part-time interim external, appointment type 14

Student or college intern classifications

Eligible Dependents

The information below reflects dependent eligibility definitions for employees and dependents enrolling in a health plan on or before June 1, 2010.

1. **Spouse.** Your current legal spouse as recognized by Ohio law.
2. **Unmarried Children under Age 19.**

You and your legal spouse's unmarried children (including legally adopted children, children for whom either has been appointed legal guardian and dependent stepchildren and foster children who normally reside with you until the end of the month in which they reach age 19).

Children of divorced or separated parents who are not residing with you but who you are required by law to support, who are under the age of 19.

3. **Unmarried Children over Age 19.**

Your unmarried children age 19 or older, who are attending an accredited school and are primarily dependent on you for maintenance and support, are eligible until the end of the month in which they either reach age 23 or cease being a student - whichever occurs first.

Student coverage is not automatic. The State will periodically request proof of school enrollment along with a completed [Affidavit of Dependent Status \(ADM 4729\)](#) form. When you provide this proof, your dependent will continue to be covered. If the requested proof is not provided to the State, their coverage ends on the last day of the birthday month.

To be considered primarily dependent, the dependent must receive the majority of his/her essentials such as food, clothing and shelter from the employee and must be enrolled in an accredited school. Attendance at an accredited school may be either full-time or part-time. Students are permitted to miss one quarter/semester per school year and still retain their coverage.

You must also provide a copy of your most recent tax return showing the child as a claimed dependent.

Under all health plans, coverage for your dependents ends no later than the last day of the month in which they turn 23, unless they have been granted an extension as described below.

4. **Unmarried Children Incapable of Self-Care**

Unmarried children of any age who are incapable of self-support due to mental retardation, severe mental illness, or physical handicap, whose disability began before age 23 and who are primarily dependent upon you. 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 (5) years following loss of coverage.

This coverage is not automatic. You must complete the applicable form for your medical plan. A form for each medical plan can be found at:

<http://das.ohio.gov/healthplanforms>

The medical form must be completed and sent to the medical plan no later than 31 days prior to the dependent's 19th birthday, or upon being diagnosed with a disabling condition between the ages of 19 and 23. Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

5. **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.

6. **Stepchildren**

Current stepchildren living in the employee's home more than 50 percent of the time.

7. **Children of Divorced Parents**

Dependents of divorced State of Ohio employees may be enrolled on both parents' family plan pursuant to a court order or joint custody agreement. However, health plans do not allow duplicate payments for services and may not coordinate benefits. Check details with your plan(s).

8. **Married State Employees with Legally Separate Dependents**

In cases of two state employees who are married and who have legally separate dependents, the employee who has coverage as a spouse may be included as a covered dependent as well as children not residing with the employee, but for whom the spouse is required by law to provide health insurance. (e.g. a natural child or children that either state employee had from a prior relationship.)

Examples of Persons NOT Eligible for Coverage as A Dependent:

A spouse from whom the employee is legally divorced or legally separated

Dependents age 19 to 23 not enrolled in an accredited school who are capable of self-support

A spouse or child currently in the military service

Children age 23 or older who are not disabled

Married children

Same sex partners

Live-in boyfriends or girlfriends

Parents or parents-in-law

Grandchildren (unless employee is the court-appointed legal guardian)

Adults who are not the employee's or spouse's child under guardianship of employee (brother, sister, aunt, uncle, etc.)

Common law spouse in which the relationship began after October 10, 1991

A child who is eligible as an employee of the state or who receives health care coverage through their own employment

Current and former stepchildren who do not reside with the employee more than 50 percent of the time

Any other members of your household who do not meet the definition of an eligible dependent

Enrollment

- Enrolling at Hire
- Enrolling/Making Changes During Open Enrollment
- Enrolling/Making Changes Due to A Qualifying Event

Enrolling at Hire

You need to enroll by submitting a completed Medical Benefit Enrollment and Change Form (ADM 4717) for health care coverage to your agency within 31 days of your date of hire, or by using eBenefits. If you do not enroll within this time frame, you must wait until the next open enrollment period or if you experience a qualifying event.

Health care coverage begins on the first day of the month following the month of your date of hire.

Enrolling/Making Changes During Open Enrollment

You may enroll, add/drop dependents or change your current elections during the open enrollment period. Open enrollment occurs at least every two years and is usually held in the spring. Coverage becomes effective on the first day of the next benefit period (typically July 1).

Enrolling/Making Changes Due to A Qualifying Event

Under normal circumstances, you cannot change or drop your coverage until open enrollment unless you experience a qualifying event. Please go to the Qualifying Events Web page at das.ohio.gov/qualifyingevents for more information.

Medicare

At age 65, you are eligible to enroll for Medicare benefits. To enroll in Medicare, contact your local Social Security office within one month of reaching age 65. Once you enroll, Medicare will coordinate its coverage with your state health plan.

Coverage Under A State Health Plan

If you are enrolled in any state health plan, that health plan will be the primary carrier and will pay first. Medicare will be the secondary carrier and will pay toward any remaining balance.

If you choose to delay enrollment in Medicare until your group health plan

terminates, there is a seven-month enrollment period available beginning with the first day of the first month in which you are no longer enrolled in a group plan. You may enroll any time during that period. There is no premium penalty for this delay in enrollment.

Employees age 65 and older with at least 40 quarters of work credits under Social Security pay no premium for Medicare Part A. Employees do pay the premiums for Part B.

No Coverage Under A State Health Care Plan

If you elect not to participate in a state-sponsored health plan, you will remain eligible for Medicare coverage. Medicare will provide your primary coverage.

Other Retirement Health Care Coverage

If you have coverage under a retirement health insurance plan and are enrolled in a state-sponsored health plan, the state's health plan will provide primary coverage.

Health Care Coverage for PERS Retirees

Employees who meet all of the following conditions must enroll in a health care plan offered by the state:

Retired from a PERS position and is re-employed in a position covered by PERS;
Receives both a salary from the state and a retirement allowance; and
Appointed as a full-time permanent (appointment code 1), part-time permanent (appointment code 4), full- or part-time internal interim, full- or part-time (appointment codes 11 and 13), 11, 12 interim (appointment code 16), or established term regular (appointment code 17) employee.

Enrollment must occur within 31 days of the date of hire for employees who meet the above criteria and are hired on or after February 9, 1994. Coverage will become effective on the first day of the month following the month in which the employee enrolls. As an example, retirees who enroll in February will have March coverage. Retirees who fail to enroll within the 31-day time frame must wait until the next open enrollment period to choose a health plan. Employees who fail to enroll in a health plan offered by the state and who have no other insurance will have their claims reduced by PERS by those amounts provided or available under the state's health plans.

A retiree may waive health care coverage only if that employee has coverage from another health plan other than through the state or PERS. The state health care coverage will be primary. PERS health care coverage will be secondary.

Health Management Program - *Take Charge! Live Well!*

This program is available to all employees enrolled in a state health plan and their eligible dependents to help members live a healthy lifestyle. Programs

include health assessments, telephone coaching, online lifestyle behavior change programs, online and print health information, condition management, worksite health screens, and a nurse advice line. Some programs may include a financial incentive for participants.

[Click here to learn more about the *Take Charge! Live Well!* program, including how to receive your incentive for participating.](#)

Claims Process

Submitting a claim pertains to employees enrolled in Ohio Med only

Network Providers

If you receive services from a network provider, the provider will submit claim forms for you. Network providers file claims directly with Medical Mutual. Medical Mutual sends payment to the provider directly.

To ensure fast claim filing, you may wish to contact Medical Mutual to determine if the health care service is covered. Show your identification card to the provider and determine if the provider is in the Ohio Med network. Ask the provider to file the claim on your behalf. Remember, not all services are covered by this or any insurance plan. Ineligible expenses are your responsibility.

Non-Network Providers

You are responsible for filing claims for services received by non-network providers. You also will be responsible for filing claims for services for which you have paid directly.

Use a separate claim form for each person for whom you are filing a claim. Submit the original bills with the claim form and be sure to keep copies for your records. Add your identification number to each bill to speed processing.

Payments for services received at non-network or non-participating providers will be made to you. You must pay the provider. (However, for persons enrolled in the Traditional plan, Medical Mutual does pay the provider directly).

Explanation of Benefits

After the claim is paid, Medical Mutual will send you an Explanation of Benefits (EOB) which describes the benefits received, lists the payments to the provider and identifies expenses, if any, for which you are responsible. However, do not make payment to providers based on EOB information. Make payment based on a bill you receive from your provider.

Claims Appeal Process - for employees enrolled in any of the state's health plans

Keep copies of all your bills, claims and correspondence. In some cases, a claim may be denied. You have the right to appeal that decision. If you wish to appeal a denied or reduced claim, there are some specific steps to take; however, check your health plan's description for details.

Department of Administrative Services Appeal

If all levels of appeal with your health plan have been exhausted and you disagree with the decision, you can file a complaint and/or request a benefit determination from the Department of Administration Services.

Submit a written request within 60 days of receiving your health plan's final written decision and supply the documentation from earlier appeals. Send your request and documentation to:

Benefit Appeal
Benefits Administration Services
30 East Broad St., 27th Floor
Columbus, OH 43215

A written decision will be given within 60 days after you submit your request.

Coordination of Benefits

You and your family members may have coverage under more than one health plan. The health plans include a coordination of benefits (COB) provision to eliminate duplication of payment for services. However, there is no COB for prescription medications.

Under COB, the plan that pays first is the primary plan.

The secondary plan pays after the primary plan.

The result is that both the state and the other insurance company pay a fair share but the combined payments by both plans will not exceed the maximum allowable reimbursement.

How COB Works

If you have coverage under more than one plan, you have a responsibility to help make COB work for you. When you incur charges, you need to submit all bills to the carrier you believe to be primary and write the name of the other carrier on the claim form. The carriers will make determinations about which is primary and which is secondary.

There is no coordination against the following kinds of coverage:

Group hospital indemnity coverage that pays less than \$100 per day

Individual (not group) policies or contracts

Medicaid

School accident coverage
Some supplemental sickness and accident policies

Determining Who Is Primary

To decide which health care plan is primary, your health plan has to consider both the coordination of benefits provisions of the other health care plan and which member of your family is involved in the claim.

The primary health care plan will be determined by rules established by the plan:

Your Health Plan as Primary

Your plan will pay the full benefit provided by your contract as if you had no other coverage.

Your Health Plan as Secondary

When your plan is the secondary plan it will make payments based on the balance left, if any, after the primary health care plan has paid. Your plan will pay no more than that balance up to the amount it would have paid had it been primary. In some cases, this may be nothing at all.

Your plan will pay only for health care services that are covered under this contract and will pay no more than the “allowable expense” for the health care involved.

If You Have a COB Dispute

If you believe that a claim was not paid properly because of COB, you should first attempt to resolve the problem by contacting your health plan. If you still are dissatisfied, and would like instructions on filing a consumer complaint, you may call the Ohio Department of Insurance at 614.644.2673 or 800.686.1526.

Enforcement of Provisions

Your health plan will coordinate your benefits, if you properly inform them of your coverage under any other health care plan. Your plan is required to determine if and to what extent you are covered under any other health care plan.

Through the utilization of your health care benefits, you and/or your dependent will be required to provide any requested information to your health plan to process the claim that has been incurred. Your health plan also may release or obtain necessary information without consent from your dependent.”

Facility of Payment

Your health plan will not pay a provider bill that has already been paid by the other health care plan. If payment that should have been made by your plan is made under any other health care plan, your plan will pay whoever paid under the other health care plan. Your health plan will determine the necessary amount under the provision, and any amount paid by your plan in this circumstance is

considered a benefit under the plan. Your plan is discharged from liability to the extent of such amounts paid for covered services.

Your Health Plan's Right of Recovery

If your plan pays more for covered services than this provision requires, it has the right to recover the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure your health plan's right to recover excess payment.

Health Plan Information

Below are links to the Web site, address, phone number and health plan description for each health plan provider. The health plan description is a detailed explanation of your benefits. If you have questions about this information, please contact your health plan at the phone number below - be sure to identify yourself as a state of Ohio enrollee.

Aetna

[Aetna July 1, 2009 Health Plan Description](#)

Group Number: 619316

Aetna

7400 W. Campus Road

New Albany, OH 43054

1-800-520-4785

[Aetna's Web Site](#)

Ohio Med

[Ohio Med Health Plan Description -- Updated 10/1/09](#)

Group Number: 228000-201

PO Box 6018

Cleveland, OH 44124

1-800-822-1152

[Ohio Med's Web Site](#)

Paramount

[Paramount July 1, 2009 Health Plan Description](#)

Group Number: 030291

1901 Indian Wood Circle

Maumee, OH 43537

1-800-462-3589

[Paramount's Web Site](#)

Please note that any behavioral health providers, dentists, and optometrists listed in the online directory are not available to State employees.

The Health Plan

[The Health Plan July 1, 2009 Health Plan Description](#)

Group Number: 0141

52160 National Rd. East

St. Clairsville, OH 43950

1-800-624-6961

[The Health Plan's Web Site](#)

UnitedHealthcare

[UnitedHealthcare Health Plan Description -- Updated 10/1/09](#)

Group Number: 702097

9200 Worthington Rd.

Westerville, OH 43082

1-877-442-6003

[UnitedHealthcare's Web Site](#)

Frequently Asked Questions

When can I enroll, terminate or make changes to my medical benefits?

There are three instances when employees can enroll, terminate from or make changes to their benefits. These times are:

- Within the first 31 days of employment
- Within 31 days of a life status event or job change
- During the annual open enrollment period

When can I change medical plans?

You may change providers either during open enrollment, or within 31 days of a change in your place of employment or home address outside of your current plan's service area.

How do I use my benefits?

Ask the health care provider you use (physician, hospital, laboratory, etc.) if they are in your plan's provider network. If they are, present your plan identification card at the time of service. You will pay any co-payment at the time of service, such as a \$20 office visit co-pay or a \$75 emergency room copay (see your plan's summary description for more details).

Your plan will pay your provider and send you an explanation of benefits (EOB) explaining what has been paid and what, if anything, has not been paid and is your responsibility.

Your provider will bill you for any amount remaining for which you are responsible.

I have a new child – how do I add him/her to my insurance?

Your newborn or adopted child may be added within 31 days of the event by using the OAKS Self-Service eBenefits enrollment process, or by submitting a [Medical Benefit Enrollment and Change form \(ADM4717\)](#) and required documentation to your agency's HR Benefits Specialist. Your agency must approve proof of your child's eligibility. If you do not enroll your child or submit proof of eligibility within 31 days of his/her birth/adoption, you may add him/her during the annual open enrollment period.

Do I need to be pre-approved for any services, or are they covered when recommended by my physician (ex: blood work)?

The following procedures must be pre-certified by your physician:

- Magnetic Resonance Imaging (MRI)
- Positron Emission Tomography (PET)
- Magnetic Resonance Angiography (MRA)

If your physician is a network provider, he/she will seek pre-approvals for you, should they be needed.

Are prescription medications covered?

Yes, prescription medications are a covered benefit. You will pay the least for generic drugs, more for name-brand drugs that are on the list of approved drugs, and you will pay the most for those brand-name drugs that are not on the plan's list of approved drugs.

What is a Deductible?

A Deductible is the amount you will have to pay before the plan begins to pay.

