Open Enrollment

1. When is Open Enrollment?
   May 12 through 11:59 p.m. May 25.

2. Does an employee who is not making any changes need to do anything during Open Enrollment?
   No. However, it is recommended that employees:
   - **Verify their contact information, e.g., home and/or mailing address so they can continue to receive important communications about any changes to current benefits.**
   - **Review your Benefits Summary by logging into myOhio.gov and clicking My Workspace to access benefit information for you and any dependents.**
   - **Ensure any dependents still meet the eligibility requirements by visiting das.ohio.gov/eligibility.**

3. If an employee enrolls for the first time during Open Enrollment (on-line) will the system automatically put the employee into the correct plan based on ZIP code?
   Yes. When the employee logs into the Benefits Enrollment screen, they will see only the third-party administrator (TPA) for which they are eligible based on their home ZIP code.

4. What are the benefit plan changes that will be effective July 1?
   - **There will be a new medical plan option, the Ohio Med Narrow Network. See the section on page 5 for more information.**
   - **There will be coverage for three anti-obesity drugs – Saxenda, Wegovy and Xenical.**
   - **Employees will have the opportunity to earn up to $1,500 in wellness incentives, and spouses can earn up to $550. See the section on Page 15 for more information.**

5. Is there a deadline to enter my open enrollment election change?
   Yes. The deadline to upload the documentation, receive approval, and enter your election changes is 11:59 p.m. May 25.

6. Do I need to provide proof or documentation to add my dependents to my coverage?
   Yes. To add a dependent to your coverage, you will be required to submit proof of eligibility when adding them in the system. You are encouraged to gather all documentation needed before taking action in the system. For a list of required documentation, review the Change in Status/Qualifying Events Matrix at das.ohio.gov/Benefits.

7. Do I need to upload a document to enroll in single coverage or to waive coverage?
   Yes. The system requires a document to be uploaded whether you are enrolling in single/family coverage or if you are waiving coverage.
   - **Single coverage – we suggest uploading a piece of paper that states you would like to enroll in single coverage.**
   - **Waiving coverage – we suggest uploading a piece of paper that states that you would like to waive your coverage.**

8. Does the documentation need to be in a specific format?
   Documents should be scanned and uploaded in a .pdf format. If you are unable to do so, taking a photo with a smart device and uploading them as a .bmp, .gif, .jpeg or .jpg, .png, or .tif image file is acceptable as well.

9. Who do I contact if I am having system-related issues during open enrollment?
Please contact your agency human resources office for assistance.

NEW Ohio Med Narrow Network Plan Option

1. What is a narrow network plan? Is the coverage the same?
A narrow network is a plan that is comprised of a smaller network of providers in each service area. Because there are less providers in the network, they can offer lower costs for services and provide better outcomes. The covered benefits and services are the same as the PPO plan, and include the same prescription drug coverage, behavioral health coverage, and wellness plan coverage.

2. Will this narrow network plan have different copay and coinsurance amounts?
No. The in-network copay, coinsurance, deductible and out of pocket maximum amounts are the same as the PPO plan.

3. What is the difference between the narrow network plan and the PPO plan?
The biggest difference is that there are NO out-of-network benefits. If you go to a provider outside of the network for non-emergency services, you will be responsible for the full cost.

4. Since there aren't any out of network benefits, will the rates be less than the PPO plan?
Yes, the rates for the narrow network plan are less than the PPO and HDHP plans.

NEW Changes to Wellness Incentives

1. What are the changes to the wellness incentives for July 1?
Employees can now earn up to $1,500 (previously $550), in wellness incentives. $600 (previously $350) for outcome-based activities and $900 (previously $200) participation activities. The outcome-based portion now includes incentives for healthy glucose levels.

2. How much can my spouse earn?
Spouses continue to be eligible for $550 per program year.

3. Are there new participation options?
Yes, incentives are available for the following new activities:
Tracking your healthy habits at least 20 days in a month, completing a Whil stress management program, and fitness center and gym membership incentives for reaching participation requirements.

Benefit Changes/Medical Rates for July 1, 2022

1. Will my office copay, deductible, or out-of-pocket maximum change for July 1, 2022?
No, there are no changes to these benefits. Please see Page 8 of the *MyBenefits* Guide or go to das.ohio.gov/OpenEnrollment to view the Guide for more information.

2. Will my prescription drug copays change for July 1, 2022?
No; prescription drug copays are not changing. Please see Page 14 of the *MyBenefits* Guide or go to das.ohio.gov/OpenEnrollment to view the Guide for more information.

3. When will the new rates be available?
There are no rate changes for the PPO or HDHP for the coming benefit year. The rates for all three plan options are included on Page 9 of the *MyBenefits* Guide and on the Open Enrollment webpage located at das.ohio.gov/OpenEnrollment.

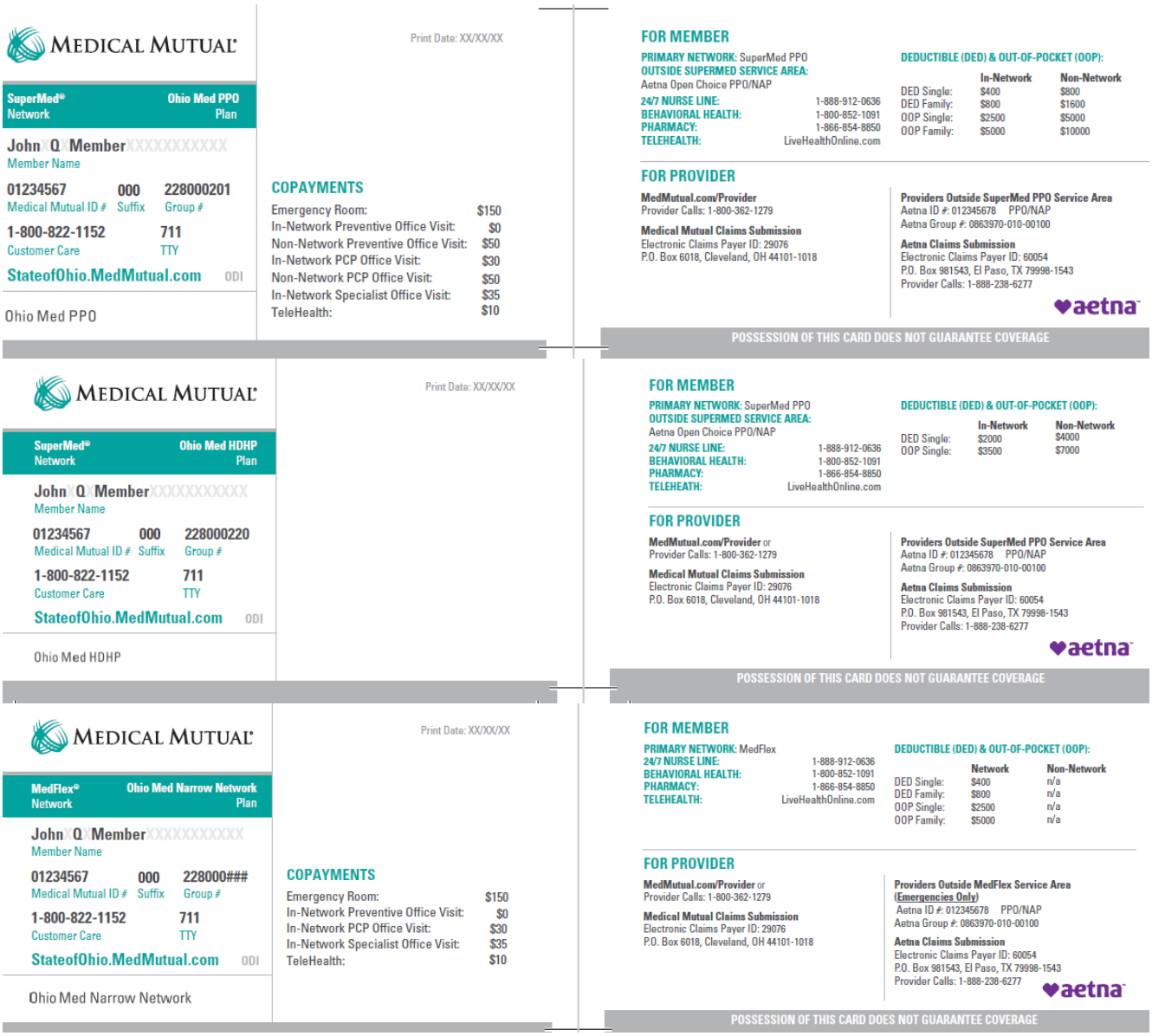
Medical Third-Party Administrators

1. Who are the third-party administrators (TPAs) that will be contracting with the State for the upcoming benefit year?
Anthem and Medical Mutual of Ohio (MMO) for medical coverage; Optum Bank (HSA), OptumRx (pharmacy), Optum Behavioral Solutions (behavioral health), Live Health Online (telehealth) and Virgin Pulse (wellness).

2. Will all employees receive new medical ID cards?
Yes, all enrolled employees will be receiving new cards.

3. Are there different ID cards for each of the TPAs?
Yes. Each TPA has a unique card, customer service number and group number. Please go to: das.ohio.gov/medical for more information.

4. When new enrollees receive medical cards will it read Ohio Med PPO, Ohio Med HDHP, Ohio Med Narrow Network, or will it have the TPA's name on it?
The medical cards issued to employees identify the state plan through the description of the Ohio Med PPO, HDHP, or Narrow Network and the appropriate administrator (Anthem or Medical Mutual) based on the first three digits of your home ZIP code. Please see the graphics below:



MEDICAL MUTUAL

Print Date: XX/XX/XX

SuperMed® Network | Ohio Med PPO Plan

John Q Member XXXXXXXXXX
Member Name

01234567 | 000 | 228000201
Medical Mutual ID # | Suffix | Group #

1-800-822-1152 | 711
Customer Care | TTY

StateofOhio.MedMutual.com ODI

Ohio Med PPO

COPAYMENTS

Emergency Room:	$150
In-Network Preventive Office Visit:	$0
Non-Network Preventive Office Visit:	$50
In-Network PCP Office Visit:	$30
Non-Network PCP Office Visit:	$50
In-Network Specialist Office Visit:	$35
TeleHealth:	$10

FOR MEMBER

PRIMARY NETWORK: SuperMed PPO
OUTSIDE SUPERMED SERVICE AREA:
Aetna Open Choice PPO/NAP

24/7 NURSE LINE:	1-888-912-0636
BEHAVIORAL HEALTH:	1-800-852-1091
PHARMACY:	1-866-854-8850
TELEHEALTH:	LiveHealthOnline.com

DEDUCTIBLE (DED) & OUT-OF-POCKET (OOP):

	In-Network	Non-Network
DED Single:	$400	$800
DED Family:	$800	$1600
OOP Single:	$2500	$5000
OOP Family:	$5000	$10000

FOR PROVIDER

MedMutual.com/Provider
Provider Calls: 1-800-362-1279

Medical Mutual Claims Submission
Electronic Claims Payer ID: 29076
P.O. Box 6018, Cleveland, OH 44101-1018

Providers Outside SuperMed PPO Service Area
Aetna ID #: 012345678 PPO/NAP
Aetna Group #: 0863970-010-00100

Aetna Claims Submission
Electronic Claims Payer ID: 60054
P.O. Box 981543, El Paso, TX 79998-1543
Provider Calls: 1-888-238-6277

aetna

POSSESSION OF THIS CARD DOES NOT GUARANTEE COVERAGE

MEDICAL MUTUAL

Print Date: XX/XX/XX

SuperMed® Network | Ohio Med HDHP Plan

John Q Member XXXXXXXXXX
Member Name

01234567 | 000 | 228000220
Medical Mutual ID # | Suffix | Group #

1-800-822-1152 | 711
Customer Care | TTY

StateofOhio.MedMutual.com ODI

Ohio Med HDHP

FOR MEMBER

PRIMARY NETWORK: SuperMed PPO
OUTSIDE SUPERMED SERVICE AREA:
Aetna Open Choice PPO/NAP

24/7 NURSE LINE:	1-888-912-0636
BEHAVIORAL HEALTH:	1-800-852-1091
PHARMACY:	1-866-854-8850
TELEHEATH:	LiveHealthOnline.com

DEDUCTIBLE (DED) & OUT-OF-POCKET (OOP):

	In-Network	Non-Network
DED Single:	$2000	$4000
OOP Single:	$3500	$7000

FOR PROVIDER

MedMutual.com/Provider or
Provider Calls: 1-800-362-1279

Medical Mutual Claims Submission
Electronic Claims Payer ID: 29076
P.O. Box 6018, Cleveland, OH 44101-1018

Providers Outside SuperMed PPO Service Area
Aetna ID #: 012345678 PPO/NAP
Aetna Group #: 0863970-010-00100

Aetna Claims Submission
Electronic Claims Payer ID: 60054
P.O. Box 981543, El Paso, TX 79998-1543
Provider Calls: 1-888-238-6277

aetna

POSSESSION OF THIS CARD DOES NOT GUARANTEE COVERAGE

MEDICAL MUTUAL

Print Date: XX/XX/XX

MedFlex® Network | Ohio Med Narrow Network Plan

John Q Member XXXXXXXXXX
Member Name

01234567 | 000 | 228000###
Medical Mutual ID # | Suffix | Group #

1-800-822-1152 | 711
Customer Care | TTY

StateofOhio.MedMutual.com ODI

Ohio Med Narrow Network

COPAYMENTS

Emergency Room:	$150
In-Network Preventive Office Visit:	$0
In-Network PCP Office Visit:	$30
In-Network Specialist Office Visit:	$35
TeleHealth:	$10

FOR MEMBER

PRIMARY NETWORK: MedFlex

24/7 NURSE LINE:	1-888-912-0636
BEHAVIORAL HEALTH:	1-800-852-1091
PHARMACY:	1-866-854-8850
TELEHEALTH:	LiveHealthOnline.com

DEDUCTIBLE (DED) & OUT-OF-POCKET (OOP):

	Network	Non-Network
DED Single:	$400	n/a
DED Family:	$800	n/a
OOP Single:	$2500	n/a
OOP Family:	$5000	n/a

FOR PROVIDER

MedMutual.com/Provider or
Provider Calls: 1-800-362-1279

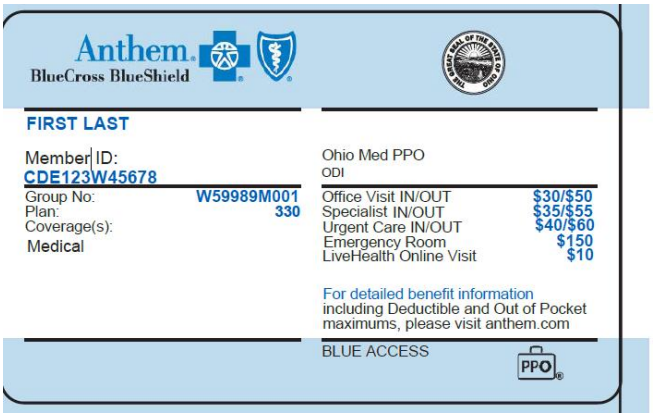
Medical Mutual Claims Submission
Electronic Claims Payer ID: 29076
P.O. Box 6018, Cleveland, OH 44101-1018

Providers Outside MedFlex Service Area
(Emergencies Only)
Aetna ID #: 012345678 PPO/NAP
Aetna Group #: 0863970-010-00100

Aetna Claims Submission
Electronic Claims Payer ID: 60054
P.O. Box 981543, El Paso, TX 79998-1543
Provider Calls: 1-888-238-6277

aetna

POSSESSION OF THIS CARD DOES NOT GUARANTEE COVERAGE



Anthem BlueCross BlueShield

FIRST LAST

Member ID:
CDE123W45678

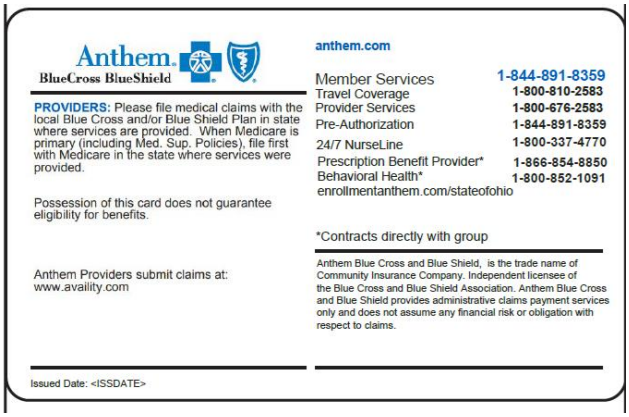
Group No: W59989M001
Plan: 330
Coverage(s):
Medical

Ohio Med PPO
ODI

Office Visit IN/OUT	$30/$50
Specialist IN/OUT	$35/$55
Urgent Care IN/OUT	$40/$60
Emergency Room	$150
LiveHealth Online Visit	$10

For detailed benefit information including Deductible and Out of Pocket maximums, please visit anthem.com

BLUE ACCESS PPO



Anthem BlueCross BlueShield

anthem.com

PROVIDERS: Please file medical claims with the local Blue Cross and/or Blue Shield Plan in state where services are provided. When Medicare is primary (including Med. Sup. Policies), file first with Medicare in the state where services were provided.

Possession of this card does not guarantee eligibility for benefits.

Anthem Providers submit claims at:
www.availity.com

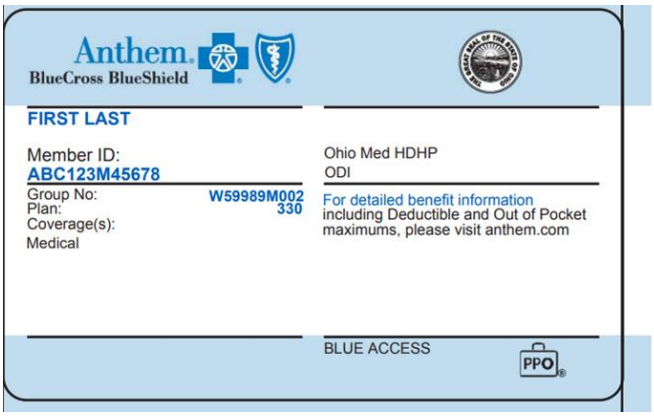
Member Services	1-844-891-8359
Travel Coverage	1-800-810-2583
Provider Services	1-800-676-2583
Pre-Authorization	1-844-891-8359
24/7 NurseLine	1-800-337-4770
Prescription Benefit Provider*	1-866-854-8850
Behavioral Health*	1-800-852-1091

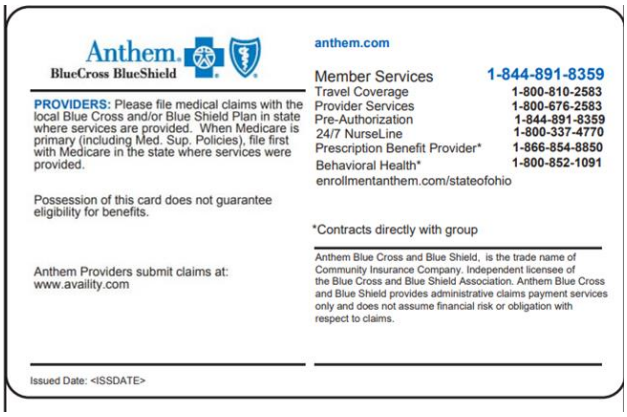
enrollmentanthem.com/stateofohio

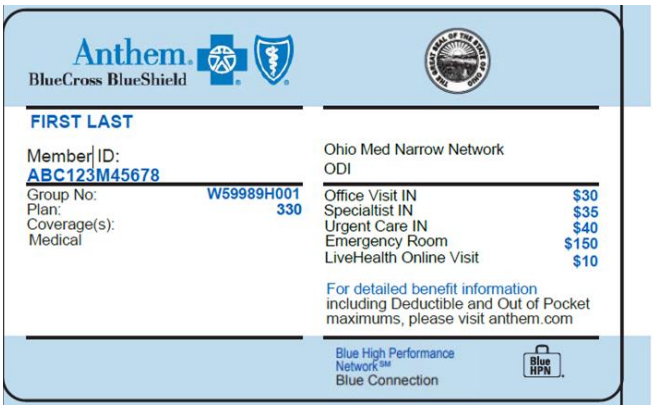
*Contracts directly with group

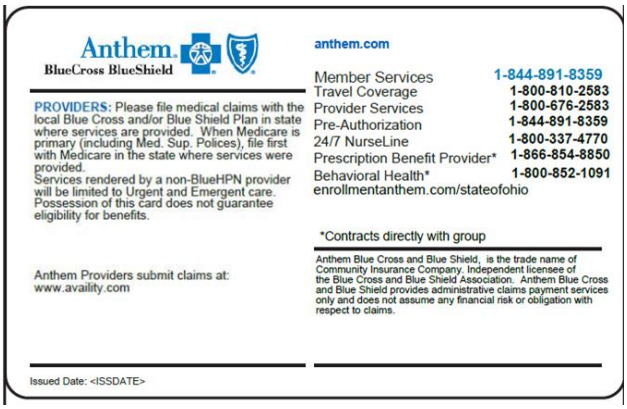
Anthem Blue Cross and Blue Shield, is the trade name of Community Insurance Company. Independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Issued Date: <ISSDATE>









5. Is there a ZIP code list for TPA assignments?
   Yes. The list is included on Page 4 of the *MyBenefits* Guide.

6. Who is the third-party administrator for employees that currently reside outside the State of Ohio?
   Anthem.

Providers

1. Where can I view a directory for the TPAs to determine if my provider is an in-network provider?
   The directory for each TPA is available on the individual TPA's website. You can search for not only in-network providers, but also providers by location or medical group.

2. Will providers be added to my TPA's network?
   TPAs have ongoing efforts to recruit providers. Their directories are updated on a regular basis.

3. If I am currently seeing a provider who is not in my TPA's network, do I have to change to an in-network provider?
   No, but you will have to pay more to be treated by a provider who is out-of-network for the Ohio Med PPO or Ohio Med HDHP. For the narrow network plan, there are NO out-of-network benefits for non-emergency services.

Behavioral Health and Substance Use Services

1. Who is the current behavioral health TPA?
   Optum Behavioral Solutions

2. Are there changes or updates to the behavioral health and substance use disorder services for the upcoming benefit year?
   No, there are no changes for the upcoming year.

High Deductible Health Plan (HDHP) and Health Savings Account (HSA)

1. What is a high deductible health plan (HDHP)?
   It is an optional plan that contains a higher deductible than the Ohio Med PPO. The monthly premium is usually lower, but you pay more health care costs before the medical TPA starts to pay its share. An HDHP will be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from taxes.

2. Who are the Ohio Med HDHP TPAs?
   Anthem and Medical Mutual.

3. What are the deductible and out of pocket maximum amounts?
   The deductible is $2,000 for single and $4,000 family for network providers, and $4,000 for single and $8,000 for family for non-network providers. If you have family coverage, the plan will begin to pay after the family deductible has been met (this is different than the PPO). The out-of-pocket maximums are $3,500 for single and $7,000 family for network providers, and $7,000 for single and $14,000 for family for non-network providers.

   These amounts encompass medical, prescription drug and behavioral health expenses.

4. How does the HDHP affect my prescription drug benefits?
   You will not pay flat-dollar copays for your prescriptions. You will pay 100% of the cost for your prescriptions until you meet your deductible; then you will pay 20% of the cost until you reach your out-of-pocket maximum.

5. How does the HDHP affect my behavioral health benefits?
   You will not pay flat-dollar copays for your behavioral health benefits. You will pay 100% of the cost for your behavioral health benefits until you meet your deductible, then you will pay 20% of the cost until you reach your out-of-pocket maximum.

6. What is a Health Savings Account (HSA)?
   A Health Savings Account (HSA) is an account that is funded by employee contributions on a pre-tax basis to help pay for eligible medical expenses, including deductibles, copays and coinsurance. To open and fund the HSA, you must meet the IRS eligibility requirements. These include:
   - **You must be covered under a high deductible health plan (HDHP).**
   - **You have no other health coverage except what is permitted by the IRS.**
   - **You are not enrolled in Medicare.**
   - **You cannot be claimed as a dependent on anyone's tax return.**

7. Who is the HSA vendor?
   Optum Bank.

8. Will the state be funding anything for the HSA?
Yes, for the benefit year beginning July 1, 2022, the state will make two equal contributions to your account in July 2022 and January 2023. The total of these two contributions will equal $1,000 for single coverage and $2,000 for family coverage.

9. Can I make contributions to my HSA?
Yes. You can elect to have money deducted from your paycheck and deposited into your account on a pre-tax basis. You can also make contributions to your account outside of payroll. Please contact Optum Bank for more information.

10. Is there a limit to what I can contribute to my HSA?
Yes. You can contribute a maximum of $3,650 for single coverage and $7,300 for family coverage. These amounts include the contributions to your account made by the state. If you are age 55 and older, you make an annual catch-up contribution of $1,000, which raises your limit to $4,650 or $8,300.

Telehealth

1. What is telehealth?
Telehealth is the delivery of medical care and health-related services that allows you to see a board-certified physician, licensed therapist, board-certified psychologist or psychiatrist 24/7 via smart phone, tablet or laptop with a camera.

2. Who is the telehealth vendor?
LiveHealth Online, a company that provides telehealth services on behalf of Anthem.

3. How much is an online medical visit through LiveHealth Online?
For members in the Ohio Med PPO, it is $10 for any visit with a physician, therapist, psychologist, or psychiatrist. For members in the Ohio Med HDHP, the cost varies – it is $59 for a medical visit, $80 for a therapist, $95 for a psychologist, $175 for the first visit with a psychiatrist and $75 for follow-up visits.

4. How do I register?
Visit livehealthonline.com or download the app from the App Store or Google Play. Please note, if you are a new enrollee that these coverages due not begin until, July 1, 2022.

5. What types of services are available?
A physician can assess common health concerns like a cold, the flu, sore throat, rash, fever or allergy. They can recommend a treatment plan and prescribe basic medications (not narcotics or controlled substances). You can also access behavioral health services.

Ancillary Benefits

1. Are the ancillary benefits the same for Anthem and MMO?
Some ancillary services, which the TPAs contract directly with, such as discount offers for nutrition programs and fitness center memberships, may be different.

2. Are there any changes to the dental and vision benefits?

There are changes to eligibility for dental and vision coverage. Effective July 1, 2022, new permanent exempt employees will be eligible to sign up for dental and vision at the same time they sign up for medical – there will be no more one-year waiting period. For those permanent exempt employees who have been employed for less than one year, there will be a special enrollment period in June 2022 that will enable them to enroll.