Open Enrollment

1. When is Open Enrollment?
   May 16 through May 29, 2024.

   If you need to upload documents, **human resources representatives will be available until 5 p.m. May 29** to receive your documents so the documents can be approved and you can make your elections. **Your elections must be completed and approved before a dependent can be added to your coverage during Open Enrollment.**

   The deadline for approval of the uploaded documentation is 11:59 p.m. May 29. Please allow enough time for review/follow-up questions after any documents have been uploaded.

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 (online) will the system automatically put the employee into the correct Third-Party Administrator (TPA) based on ZIP code?
   Yes. When the employee logs into the Benefits Enrollment screen, they will see only the TPA for which they are eligible based on their home ZIP code.

4. What are the new medical benefit changes that will be effective July 1?
   - **Coverage for the new weigh loss medication, Zepbound.**
   - **The LiveHealth Online telehealth copay will increase to $15.**

5. Is there a deadline to enter my Open Enrollment election change?
   Yes. The deadline to receive approval and enter your election changes is 11:59 p.m. May 29, 2024.

   If you need to upload documents, **human resources representatives will be available until 5 p.m. May 29** to receive your documents so the documents can be approved and you can make your elections. **Your elections must be completed and approved before a dependent can be added to your coverage during Open Enrollment.**

   The deadline for approval of the uploaded documentation is 11:59 p.m. May 29. Please allow enough time for review/follow-up questions after any documents have been uploaded.

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 or family coverage, or if you are waiving coverage.
   - **Single coverage – we suggest uploading a document that states you would like to enroll in single coverage.**
   - **Waiving coverage – we suggest uploading a document 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, taking a photo with a device and uploading them as a .bmp, .gif, .jpeg or .jpg, .png, or .tif image file is acceptable. Note: Live photos from iPhone users cannot be viewed for approval. Please ensure it is a still photo.

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

10. I do not plan on making any changes, what will happen if I just start a new enrollment just to look at the different options?
If you start an Open Enrollment event without completing it, you may risk negatively impacting your current benefits by accidentally removing a dependent or a current benefit. We recommend reviewing the MyBenefits guide or speaking with your agency human resources representative if you have questions about any changes to your benefits.

Copay and Deductible Changes/Medical Rates for July 1, 2024

1. Will my office copay, deductible, or out-of-pocket maximum change for July 1, 2024?
The only change is for telehealth visits, which is increasing to $15. All other amounts remain the same. Please see Page 9 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, 2024?
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?
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

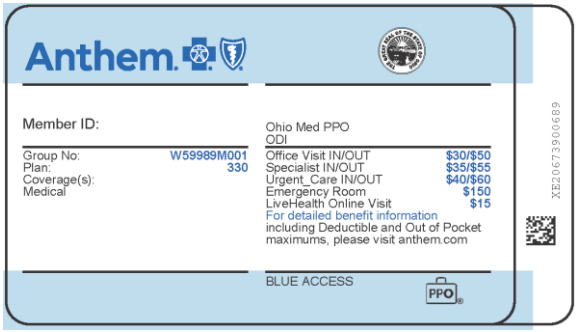
1. Who are the third-party administrators (TPAs) for the upcoming benefit year?
Anthem and Medical Mutual of Ohio for medical coverage; Baker Tilly Vantagen (FSA and HSA), OptumRx (prescription drugs), Optum Behavioral Health (behavioral health), LiveHealth Online (telehealth) and Virgin Pulse (wellness).

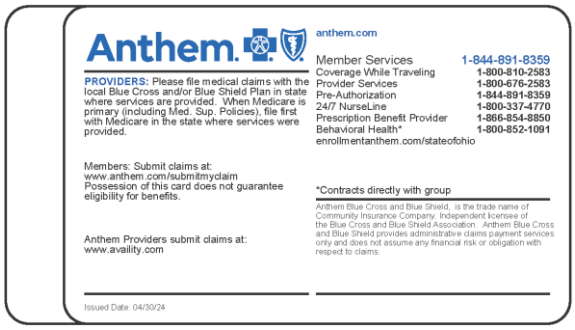
2. Are there different ID cards for each of the TPAs?
Yes. Each TPA has a unique card, customer service number and group number. Please go to: DAS.Ohio.gov/Medical for more information.

3. When new enrollees receive medical cards will it read Ohio Med PPO, Ohio Med HDHP, Ohio Med NN, 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, Ohio Med HDHP, or Ohio Med NN and the appropriate administrator (Anthem or Medical Mutual) based on the first three digits of your home ZIP code. Refer to the following Anthem and Medical Mutual of Ohio card images.

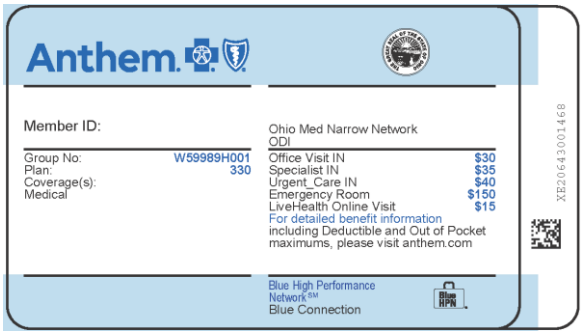
Anthem Cards

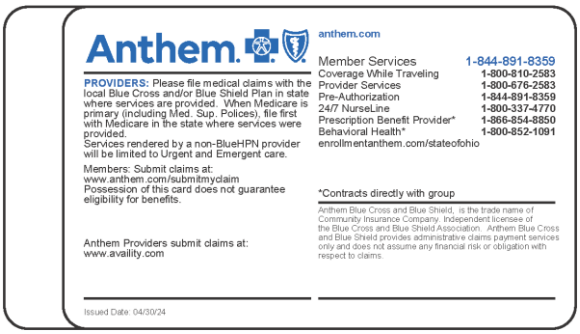
Ohio Med PPO



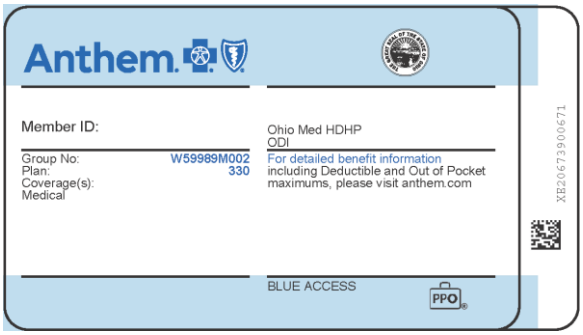


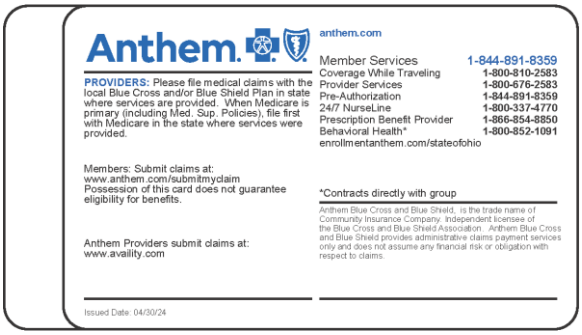
Ohio Med NN





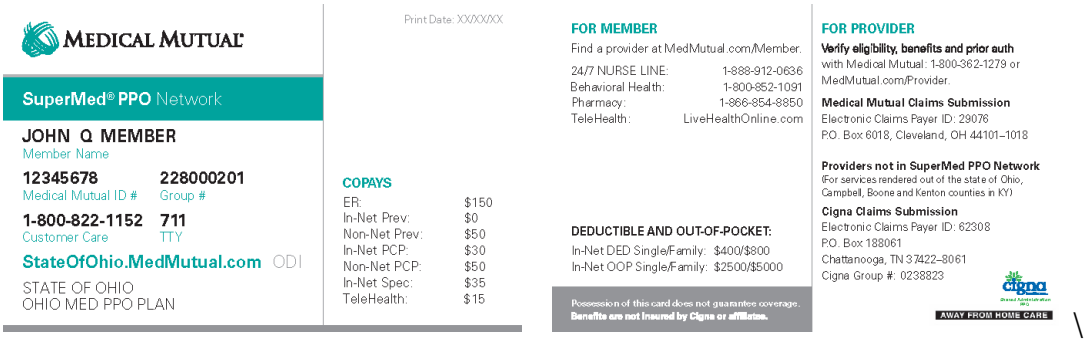
Ohio Med HDHP



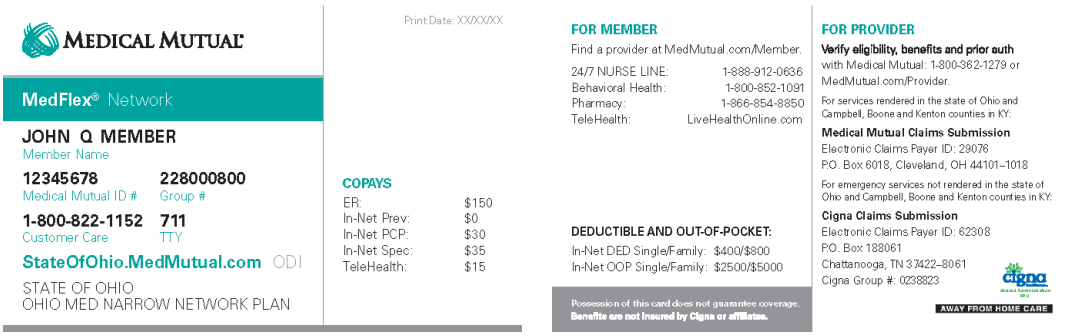


Medical Mutual of Ohio Cards

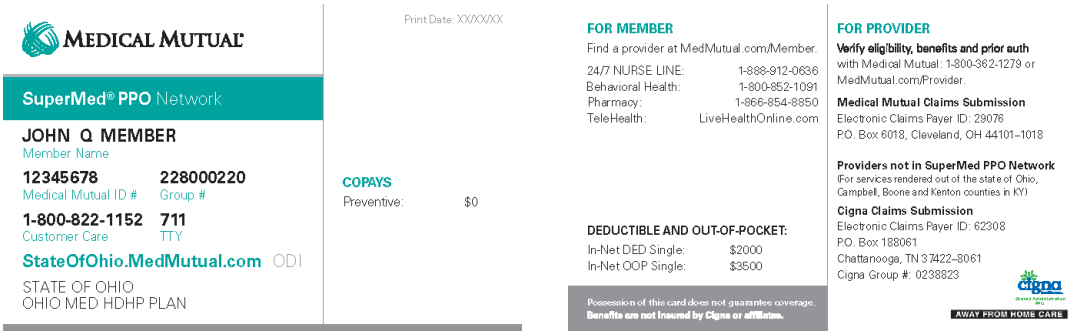
Ohio Med PPO



Ohio Med NN



Ohio Med HDHP



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

5. Who is the TPA for employees that currently reside outside the State of Ohio?
Anthem.

6. Will I receive a new medical card if I make no changes in my elections?
Members currently enrolled in the Ohio Med PPO and Ohio Med NN plans will receive new medical cards to reflect the updated telehealth copay. HDHP members will not be receiving a new medical card.

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 PPO or HDHP. For the Narrow Network plan, there are NO out-of-network benefits for non-emergency services.

High Deductible Health Plan and Health Savings Account

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 TPAs for the Ohio Med HDHP?
   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?
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?
Baker Tilly Vantagen.

8. Will the state be funding anything for the HSA?
Yes, the state will make equal contributions to your account every pay period throughout the year. The total of these 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 Baker Tilly Vantagen for more information.

10. Is there a limit to what I can contribute to my HSA?
Yes. For 2024, you can contribute a maximum of $4,150 for single coverage and $8,300 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 $5,150 or $9,300.

Narrow Network Plan (NN) 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. Does the 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 narrow network for non-emergency services, you will be responsible for the full cost.

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

Behavioral Health and Substance Use Services

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

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.

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 $15 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, these coverages do not begin until July 1, 2024.

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.

Dental and Vision Benefits

1. Are there any changes to the dental and vision benefits?
   Yes, there are changes to dental and vision dependent eligibility for all employees, and changes to exempt vision benefits effective July 1:

   Dependents are now covered for dental and vision up to the age of 26 if they are:
   - **A dependent child.**
   - **An Ohio resident, or a full-time student at an out-of-state institution.**
   - **Unmarried.**

- **NOT employed by an employer that offers coverage where the child is eligible.**
- **NOT eligible for Medicaid/Medicare.**

For exempt vision benefits, there is an Increase in the maximum allowance for eyeglass frames: from $120 to $160, and for contact lenses: from $125 to $160.

Ancillary Benefits

1. Are the ancillary benefits the same for Anthem and Medical Mutual of Ohio?
   Although some ancillary services may be the same, Anthem and Medical Mutual of Ohio have their own contracts to offer discounts such as nutrition programs and fitness center memberships.