

Open Enrollment

1. When is Open Enrollment?
May 8 through May 21, 2025.

If you need to upload documents, **human resources representatives will be available until 5 p.m. May 21** 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 21. 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 information 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](https://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 based on ZIP code?
Yes. When the employee logs into the Benefits Enrollment screen, they will see only the third-party administrator for which they are eligible based on their home ZIP code.
4. What are the new benefit changes that will be effective July 1?
 - **GLP-1 medications for obesity (Saxenda, Wegovy, Zepbound, etc.) will no longer be covered. Existing prior authorizations will be honored until they expire.**
 - **The Ohio Med Narrow Network plan will now be named Ohio Med Select. (This is a name change only.)**
 - **The vision vendor for exempt employees will be changing from EyeMed Vision Care to VSP Vision Care.**
5. Is there a deadline to enter my Open Enrollment election change?
Yes. The system will allow document submission for approval and entry of your election changes up to 11:59 p.m. May 21, 2025. Please be aware that the myBenefits Customer Support team for document approval and troubleshooting system-related issues will only be available until 5 p.m. May 21, 2025. Documents must be approved by 5 p.m. May 21 and then the election can be made up to 11:59 p.m.

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. Please review the eligibility matrix to see what documents are required for enrollment. 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 > [About my Benefits](#) > [Eligibility and Enrollment](#).
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, you can take a photo with a device and upload the image as a .bmp, .gif, .jpeg or .jpg, .png, or .tif file. Note: live photos from iPhones cannot be viewed for approval. Please ensure the image 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 representative 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?
IMPORTANT: 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, the Benefits Summary tab, or speaking with your agency's human resources representative if you have questions about your benefits. Review your Benefits Summary by logging into myOhio.gov and clicking My Workspace to access benefit information for you and any dependents.

Copay and Deductible Changes/Medical Rates for July 1, 2025

1. Will my office copay, deductible, or out-of-pocket maximum change in the new benefit year?
All copays, deductibles, and out-of-pocket maximum amounts remain the same. 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, 2025?
No, prescription drug copays are not changing. Please see Page 14 of the MyBenefits Guide or go to [DAS.Ohio.gov/OpenEnrollment](https://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](https://das.ohio.gov/OpenEnrollment).




Medical Third-Party Administrators

1. Who are the third-party administrators for the upcoming benefit year?
 - **Anthem and Medical Mutual of Ohio (medical coverage)**
 - **Baker Tilly Vantagen (flexible spending accounts and health savings accounts)**
 - **Optum Rx (prescription drugs)**
 - **Optum Behavioral Health (behavioral health)**
 - **LiveHealth Online (telehealth)**
 - **Personify Health (wellness)**
2. Are there different ID cards for each of the third-party administrators?
Yes. Each third-party administrator has a unique card, customer service number and group number. Please go to: [DAS.Ohio.gov/Medical](https://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 Select, or will it have the third-party administrator'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 Select plan and the appropriate administrator (Anthem or Medical Mutual) based on the first three digits of your home ZIP code. Please see the sample graphics below:

Anthem: Ohio Med PPO




Anthem: Ohio Med HDHP

 	
Member ID: Group No: W59989M002 Plan: 330 Coverage(s): Medical	Ohio Med HDHP ODI For detailed benefit information including Deductible and Out of Pocket maximums, please visit anthem.com
BLUE ACCESS 	
Issued Date: 04/30/24	


Anthem: Ohio Med Select

 	
Member ID: Group No: W59989H001 Plan: 330 Coverage(s): Medical	Ohio Med Select ODI Office Visit IN \$30 Specialist IN \$35 Urgent Care IN \$40 Emergency Room \$150 LiveHealth Online Visit \$15 For detailed benefit information including Deductible and Out of Pocket maximums, please visit anthem.com
Blue High Performance Network  Blue Connection	
Issued Date: 04/30/24	



Medical Mutual of Ohio: Ohio Med PPO

 MEDICAL MUTUAL		Print Date: XX/XX/XX
SuperMed® PPO Network		
JOHN Q MEMBER Member Name		
12345678 Medical Mutual ID #	228000201 Group #	COPAYS ER: \$150 In-Net Prev: \$0 Non-Net Prev: \$50 In-Net PCP: \$30 Non-Net PCP: \$50 In-Net Spec: \$35 TeleHealth: \$15
1-800-822-1152 711 Customer Care TTY		
StateOfOhio.MedMutual.com ODI		
STATE OF OHIO OHIO MED PPO PLAN		

Medical Mutual of Ohio: Ohio Med HDHP

 MEDICAL MUTUAL		Print Date: XX/XX/XX
SuperMed® PPO Network		
JOHN Q MEMBER Member Name		
12345678 Medical Mutual ID #	228000220 Group #	COPAYS Preventive Visit: \$0
1-800-822-1152 711 Customer Care TTY		
StateOfOhio.MedMutual.com ODI		
STATE OF OHIO OHIO MED HDHP PLAN		

Medical Mutual of Ohio: Ohio Med Select

 MEDICAL MUTUAL		Print Date: XX/XX/XX	
MedFlex® Network		FOR MEMBER Find a provider at MedMutual.com/Member. 24/7 NURSE LINE: 1-888-912-0636 Behavioral Health: 1-800-852-1091 Pharmacy: 1-866-854-8850 Employee Assistance Plan: 1-800-221-6327 TeleHealth: LiveHealthOnline.com	
JOHN Q MEMBER Member Name 12345678 228000803 Medical Mutual ID # Group # 1-800-822-1152 711 Customer Care TTY StateOfOhio.MedMutual.com ODI STATE OF OHIO OHIO MED SELECT PLAN		COPAYS ER: \$150 In-Net Prev: \$0 In-Net PCP: \$30 In-Net Spec: \$35 TeleHealth: \$15 DEDUCTIBLE AND OUT-OF-POCKET: In-Net DED Single/Family: \$400/\$800 In-Net OOP Single/Family: \$2500/\$5000 <small>Possession of this card does not guarantee coverage. Benefits are not insured by Cigna or affiliates.</small>	
		FOR PROVIDER Verify eligibility, benefits and prior auth with Medical Mutual: 1-800-362-1279 or MedMutual.com/Provider. For services rendered in the state of Ohio and Campbell, Boone and Kenton counties in KY: Medical Mutual Claims Submission Electronic Claims Payer ID: 29076 P.O. Box 6018, Cleveland, OH 44101-1018 For emergency services not rendered in the state of Ohio and Campbell, Boone and Kenton counties in KY: Cigna Claims Submission Electronic Claims Payer ID: 62308 P.O. Box 188061 Chattanooga, TN 37422-8061 Cigna Group #: 0238823  AWAY FROM HOME CARE	

- Is there a ZIP code list for third-party administrator assignments?
Yes. The list is included on Page 4 of the MyBenefits Guide.
- Who is the third-party administrator for employees that currently reside outside the State of Ohio?
Anthem.
- Will I receive a new medical card if I make no changes in my elections?
Members currently enrolled in the Ohio Med NN plan will receive a new card that shows the name change to Ohio Med Select. Members in the Ohio Med PPO and Ohio Med HDHP will not be receiving a new medical card.

Providers

- Where can I view a directory for the third-party administrators to determine if my provider is an in-network provider?
The directory for each third-party administrator is available on the individual third-party administrator's website. You can search for not only in-network providers, but also providers by location or medical group.
- Will providers be added to my third-party administrator's network?
Third-party administrators are always making efforts to recruit providers. Their directories are updated on a regular basis.
- If I am currently seeing a provider who is not in my third-party administrator'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 Select 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 pre-tax dollars.
2. What are the deductible and out-of-pocket maximum amounts?
The deductible is \$2,000 for single coverage and \$4,000 for family coverage for network providers, and \$4,000 for single coverage and \$8,000 for family coverage for non-network providers. If you have family coverage, the plan will begin to pay only after the entire family deductible has been met (this is different than the PPO).

The out-of-pocket maximums are \$3,500 for single coverage and \$7,000 for family coverage for network providers, and \$7,000 for single coverage and \$14,000 for family coverage for non-network providers.

These amounts encompass medical, prescription drug, and behavioral health expenses.
3. 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.
4. 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.
5. 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.**

6. Who is the HSA vendor?
Baker Tilly Vantagen.
7. 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.
8. 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.
9. Is there a limit to what I can contribute to my HSA?
Yes. For calendar year 2025, you can contribute a maximum of \$4,300 for single coverage and \$8,550 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 \$5,300 or \$9,550.

Ohio Med Select Plan Option (previously called the narrow network plan)

1. What is a the Select plan? Is the coverage the same?
The Select plan is comprised of a smaller network of providers in each service area. Because there are fewer 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 Select 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 Select 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, are the rates less than the PPO and HDHP plans?
Yes, the rates for the Select plan are less than the PPO and HDHP plans.

Behavioral Health and Substance Use Services

1. Who is the current behavioral health third-party administrator?
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.
3. How much is an online medical visit through LiveHealth Online?
For members in the Ohio Med PPO or Ohio Med Select plans, 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, 2025.
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?
There are no changes to benefits, but effective July 1, 2025, the vision vendor for exempt employees is changing from EyeMed Vision Care to VSP Vision Care. Be sure to verify that your current provider is a part of the VSP Advantage network. This change will happen automatically, so employees do not need to log in to Self-Service to switch plans.

Ancillary Benefits

1. Are the ancillary benefits the same for Anthem and Medical Mutual of Ohio?
Some ancillary services, such as discount offers for nutrition programs and fitness center memberships, may be different, depending on who they contract with. Visit your medical third-party administrator's microsite for full details.