HEALTH CARE:

QUESTIONS & ANSWERS

Q: As a state employee, how do I get health care?

A: All permanent state employees are eligible for health care. Your health benefits include medical, prescription drug, behavioral health, dental, vision, and the wellness program. To be eligible for your health benefits, you must enroll in a health plan. New employees typically enroll shortly after beginning work for your health benefits, except for dental and vision. You are eligible for dental and vision after one year of state service. On-going employees have the chance to change plans or begin coverage at open enrollment, typically once a year. To maintain premium payment with pre-tax earnings, any changes outside of open enrollment must be in compliance with the rules of the IRS. Qualified coverage changes may occur if requested within thirty-one days of the event. For further information, see Article 20.

Q: What health care plan choices do I have?

A: The State offers Ohio Med medical plan. There are three medical plan options to choose from. The three plans are Ohio Med PPO, Ohio Med NN, and Ohio Med HDHP. To help you decide which plan is best for you compare the options at DAS.Ohio.gov/Medical and click the Compare the Medical Plan Options tile.

Q: Who pays for the health benefits?

A: All State of Ohio health plans are self-funded programs. The cost of benefits is funded by contributions from you and the State of Ohio. You pay 15% of the monthly premium and the State pays for the other 85%.

Q: What is a Health Savings Account?

A: The Health Savings Account (HSA) is an account that is funded by the employer and employee contributions on a pre-tax basis to help pay for eligible medical expenses. The HSA is only available as part of the Ohio Med HDHP option. The HSA is set up online through Baker Tilly Vantagen, myFlexDollars.com, and is a personal bank account. The current contribution limit for individual coverage is $3,850 and $7,750 for family. HSA funds are yours to keep, there is no “use it or lose it” rule, the funds stay with you even if you leave employment with the state or retire. Typically, employers will make contributions, based on the type of coverage, to your account.

Q: What are Centers of Excellence?

A: A center of excellence is a program within a healthcare institution that is assembled to have a high concentration of expertise and related resources centered on a particular area of medicine. You can benefit from utilizing a center of excellence institution because a team of health providers work together to provide a higher level of care and service and deliver better results and outcomes with often lower costs.

Q: Will my family be covered?

A: You can cover your spouse and eligible dependent children. Refer to Article 20 of the Agreement for eligibility requirements. Effective July 1, 2024, the dependent age qualification changed for dental and vision benefits. You can cover your unmarried dependents up to age 26 for these benefits provided the dependent is an Ohio resident or full-time out-of-

state student, not employed by an employer that offers coverage, and not eligible for Medicaid/Medicare. For other eligibility questions, refer to DAS.Ohio.gov/Eligibility or for dental/vision contact UBT.

Q: What is a deductible?

A: A deductible is an amount you pay as an individual or as a family before health insurance pays benefits. The deductible can vary depending on the type of coverage you have, the plan you select, and whether your provider is In-Network or Out-of-Network. For single coverage you pay $400 for the PPO and NN plans and $2,000 for the HDHP for In-Network providers. For family coverage you pay $800 for the PPO and NN plans and $4,000 for the HDHP for In-Network providers. The deductible is higher for Out-of-Network providers.

Q: What is a co-pay?

A: A co-pay is a fixed amount you pay, and insurance pays the rest. The cost can vary depending on if your office visit is with a doctor or a specialist. For a doctor visit, you pay $30 for In-Network and $50 for Out-of-Network. For a specialist visit, you pay $35 for In-Network and $55 for Out-of-Network.

Q: What is an Out-of-Pocket Maximum?

A: This is a limit to the costs you will have to share before your health insurance pays 100%. This can vary depending on if you see an In-Network or Out-of-Network provider. The out-of-pocket maximum (OPM) for an individual is $2,500 and $5,000 for family for In-Network. The OPM for an individual is $5,000 and $10,000 for Out-of-Network. Your deductible, co-pays, and other costs your pay for an allowable procedure counts toward your OPM. Once your allowable costs add up to the OPM, all other costs are covered at 100%.

Q: What about prescription drugs?

A: All health plans offer prescription drug benefits and are included if you enroll in the medical plan. These benefits are provided by OptumRx. There are several changes and additional coverages to the program, such as, Anti-Obesity Medication, Diabetes Management Program, and Specialty Drug Management Program. For a program description refer to DAS.Ohio.gov/PrescriptionDrug.

Q: What are my prescription costs?

A: The cost for a 30-day supply is a $10 co-pay for generic drugs, a $40 co-pay for preferred brand-name, and a $75 co-pay for non-preferred brand-name, generic unavailable. If the generic drug is available, the cost is higher. A voluntary mail order drug program that offers savings for purchasing a 90-day supply is available. The cost for a 90-day supply is a $25 co-pay for generic drugs, a $100 co-pay for preferred brand-name, and a $187.50 co-pay for non-preferred brand-name, generic unavailable. If the generic drug is available, the cost is higher. For more information visit OptumRx.com or contact OptumRx at 866-854-8850.

Q: What are some other programs offered?

A: Behavioral Health administered by Optum Behavioral Health, Wellness (known as Take Charge|Live Well) administered by Virgin Pulse, and Telehealth services administered by LiveHealth Online are provided to all participants enrolled in any health plan, no matter whether you choose Ohio Med PPO, Ohio Med NN, or Ohio Med HDHP.

Q: What is my dental, vision, and life insurance benefits?

A: These benefits are provided through the Union-operated Benefits Trust. You should receive information from UBT within a month of hiring, at the

time you complete your first year of continuous State service, and at open enrollment. Dental benefits are administered by Delta Dental. Vision benefits are administered by either VSP or EyeMed. Life insurance benefits are administered by Prudential. For more information, contact UBT at 1-800-228-5088 or visit BenefitsTrust.org.

Q: What additional life insurance options do I have?

A: Supplemental life insurance is available upon hire (when you have no paid life insurance coverage) to help protect your family financially. You can elect inexpensive term life insurance for yourself and eligible dependents upon hire and during open enrollment. Coverage levels are available with and without providing proof of good health. Visit benefitstrust.org for more information.

Q: What is the legal plan?

A: The Legal Services Plan gives you easy and low-cost access to a wide variety of personal legal services. The plan has a minimum participation period- you may only leave the plan during an open enrollment period. For a detailed list of services, limitations and exclusions, visit benefitstrust.org.

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