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, but you must enroll in a health care plan. New employees typically enroll shortly after beginning work—information including a benefits comparison chart should be provided by the employing agency at the time of hire. On-going employees have the chance to change plans or to begin coverage at open enrollment, typically once a year.

Q: What health care choices do I have?

A: The Ohio Med PPO health plan is available In all areas. Most counties also have one or two HMOs to select from as well. Generally speaking, you pay 15% of the monthly premium and the State pays the other 85%. The union may agree to reduce the number of plans available.

Q: Will my family be covered?

A: You can cover your spouse and eligible dependent children (see Article 20.01D of the Agreement). The monthly premium for family coverage is higher than for single. If you cover a spouse, you pay an additional $12.50 per month surcharge.

Q. What benefits will I receive?

A. All plans must provide a generous set of core benefits, including preventative and primary care benefits. In the latest round of collective bargaining, coverage was increased for a number of preventative services from 80% to 100%. (See Article 20.03 for details about the benefits.) The office co-pay was eliminated for these preventive services.

Q: What are the differences between Ohio Med and the HMOs?

A: While it used to be the case that in general, HMOs provided more primary care and preventive benefits, and had lower out-of pocket costs while being more restrictive, this is really no longer the case. More and more HMOs and the Ohio Med PPO have a very similar level of benefits covered. Both cover a high level of preventive care at little out-of-pocket cost to the employee. And now both types of plans have greater restrictions on the drugs that are covered as all plans have the same drug formulary. You should assess your own likely health care needs and those of your family when making your health plan choice. Check the benefits comparison chart for the most detailed information. HMO's only cover benefits provided by by doctors and hospitals in their network. The Ohio Med PPO covers services provided by doctors and hospitals both in the network and out of network services are paid at a higher rate.

Q: What about mental health or substance abuse treatment services?

A: No matter what health plan you choose, You will receive MH/SA services

through United Behavioral Health, a nationally recognized company (1-800-852-1091). It offers a wide range of services with low co-pays. However, if you fail to select a health plan, you will not have MH/SA coverage.

Q: What about prescription drugs?

A: All health plans offer prescription drugs. The cost for a 30-day supply is a $10.00 co-pay for generic drugs, a $25.00 co-pay for formulary drugs and a $50.00 co-pay for non-formulary drugs. A voluntary mail order drug program that offer savings for purchasing a 90-day supply of drugs is available. Co-pays for mail order drugs are higher (two and one-half times) because you get a three month supply. Even with that, mail order programs save employees money over the long run.

Q. What is a drug formulary?

A. All plans have a drug formulary. A drug formulary is a list of drugs from which your doctor can prescribe and includes brand name drugs and generic medicines. If your doctor prescribes a drug not on the formulary, you will have to pay a higher co-pay to get a non-formulary drug. If your doctor calls the plan and explains that the drugs on the formulary will not work for you, you can get the non-formulary drug at the lower formulary co-pay. Other plans may be able to do this as well. Please check with your pharmacy benefit manager.

Q. Why do plans have formularies?

A. Formularies save a lot of money. What Pharmacy Benefit Managers (the companies that administer your prescription drug benefit- like Medco) do is review all the drugs in a particular therapeutic class. Any drugs that are not effective or dangerous are weeded out. Any drugs that are a step above in their effectiveness or have significantly lower side effects are included. Of those drugs that are considered equally effectively, the PBM then decides that it may, for example, have only 3 of the 5 drugs in that class on its list. It does this to position itself to negotiate the best possible price. The PBM knows if it can go to the 5 drug manufacturers and indicate it will limit the number of drug manufacturers and indicate it will limit the number of drugs on its list to 3, it will get a deeper discount for the drug. This creates competition among the drug manufacturers.

Q. Does this mean I have to make sure my doctor prescribes a drug from my plan's formulary?

A. Yes, or be prepared to pay the higher non-formulary co-pay. Under Ohio law all health plans must mail the formulary list to enrollees annually. Take this list with you to the doctor to ensure you are getting a formulary drug. Your doctor also has a copy of your formulary, but most don't check it unless you ask them to. If you don't have your list when you visit the doctor, call your pharmacy to find out if the drug is on the formulary before you leave the office. You may get a copy of your formulary from DAS benefits administration section at any time.

Q: What kind of customer service is available?

A: All health plans offer a toll free customer service number. A population health management company helps people prevent disease and offers additional assistance for individuals with chronic conditions such as asthma or diabetes.

Q. Are voluntary supplemental benefit plans offered to State employees through payroll deduction?

A. Employees enrolled through payroll deduction in voluntary supplemental benefit plan as of March 1, 2006 can continue to participate in those programs. After March 1, 2006, no additional employees will be permitted to enroll in such plans unless the plan has been selected by the State through a process to ensure that the products are reviewed and approved by either the State of the Union's Benefits Trust.

Q. What about dental, vision and life insurance benefits?

A. These benefits are provided through the Union-operated Benefits Trust. You should receive information from it within a month of hiring, at the time you complete your first year of continuous State service, and at open enrollment. Call 1-800-228-5088 for Benefits Trust information.

Q. What is a deductible?

A. A deductible is an amount you pay as a individual or as a family before health insurance pays benefits. You do not have to pay a deductible for office visits because you pay an office co-pay of $20.00 to see a doctor. The deductible for an individual is $200.00 and is $400.00 for a family.

Q. What is a co-pay?

A. A co-pay is a fixed amount you pay and insurance pays the rest. For example, you pay a $20.00 co-pay for an office visit and insurance pays the rest. Your co-pay does not apply to the deductible.

Q. What is an out –of pocket maximum limit?

A. This is a limit to the costs you will have to share before your health insurance pays 100%. The out-of-pocket maximum (OPM) for an individual is $1500 and $3000 for a family. For example, your deductible counts toward your (OPM) and so do other costs you pay such as the 20% share you might pay for a procedure. Once your costs add up to $1500 / single or $3000 / family all other costs are covered at 100%.

References

Article 20

OCSEA

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