

Health Insurances ***(Medical, Prescription, Dental & Vision)***

Frequently Asked Questions ***(FAQ)***

March 2006

Plan Administrator: Medical Mutual of Ohio

Plan Type: PPO Network Comprehensive
Major Medical

Plan Numbers: Plan A Non Bargaining 228339009
Plan B Non Bargaining 228339109
Plan C Non Bargaining 228339209

Plan A Bargaining (Toll) 228339008
Plan B Bargaining (Toll) 228339108

Plan A Bargaining (Maint) 228339010
Plan B Bargaining (Maint) 228339110

Frequently Asked Questions (FAQ)

Q. My child is going to college this year. Will my Ohio Turnpike Commission health insurance cover him?

A. Yes, your child will be covered if you have 2-person or family coverage, as long as your child is under age 23, unmarried and enrolled as a full-time student at a university or college. Annual certification is required to demonstrate that the student meets the institution's requirements for full-time status.

Q. What is the difference between a deductible, coinsurance and copayment?

A. Each Benefit Period, you must pay the dollar amount specified in the Schedule of Benefits as the Deductible before the Plan will begin to provide benefits. For Ohio Turnpike Commission employees, the Benefit Period is January 1 – December 31.

The **deductible** is the amount of expenses incurred and paid by you for covered services before the plan starts to provide benefits. This requires you to submit to Medical Mutual copies of all your bills paid by you. Copayments will not apply to the deductible.

Coinsurance is the amount after you meet the applicable deductible, which you may be responsible for as specified in your Schedule of Benefits. Refer to your plan booklet for the Schedule of Benefits.

For some Covered Services, you may be responsible for paying a **Co-payment** at the time services are rendered.

Q. How do I apply for benefits when I have a claim?

A. In most cases, your health care provider will submit a claim on your behalf. If you submit the claim yourself, you will need to use a claim form, which can be accessed from Medical Mutual of Ohio's website at <http://www.MedMutual.com> under the Members' section or by contacting Human Resources and a form will be mailed to you. Keep in mind that Medical Mutual is not obligated to reimburse for Covered Services on your behalf later than one year after services have been received.

Q. My spouse and I both carry insurance for each other. He is also covered under my plan as well. How does secondary insurance work?

A. For the employee, the Ohio Turnpike Commission (OTC) health plan is primary. For your spouse, the OTC health plan is secondary. This means that MMO will make payment based on the balance left after your spouse's primary health care plan has paid, but no more than the balance. Payment will only be for Covered Services, all procedural plan requirements must be followed (i.e., pre-certification), and MMO will pay no more than the "allowable expense" for the health care involved.

Q. How does my insurance work with Medicare?

A. For active employees at work, regardless of age:

- If married and the employee maintains a family plan, MMO is the primary for both the employee and spouse regardless of the spouse's age.
- If single, MMO is always primary.

For disabled employees under age 65:

- If the employee has Medicare due to disability, Medicare is primary.
- If married and the spouse is under age 65, MMO is primary for the spouse.
- If married and the spouse is over age 65, MMO is secondary for the spouse.

If spouse is disabled on Medicare:

- The rules follow the status of the employee as to who is primary – if the employee is actively working, MMO is primary regardless of the employee's age.

Q. Medical Mutual denied my claim and I think they should have covered the service(s), what can I do?

A. First, check your plan booklet to see if the service is covered, limited or excluded. The next step is to review the disputed claims section of your plan booklet under "Filing an Appeal."

To file an appeal, either contact the MMO Customer Service telephone number toll-free at 1-800-232-7400 or write a letter to:

Medical Mutual of Ohio Turnpike Commission Member Appeals Unit
MZ: 01-1B-4809
P.O. Box 94580
Cleveland, Ohio 44101-4580
FAX: 216-687-7990

Your appeal must include the following information:

- Card holder's full name
- Patient's full name
- Identification number
- Claim number, if a claim has been denied
- Reason for the appeal
- Date of services
- Provider/facility name
- Any other supporting information or records, X-rays, or photographs you would like considered in the appeal.

First-level appeals must be filed within 180 days from your receipt of the Notice of Denial of Benefits. You also have the right, upon written request, to have reasonable access to and copies of documents, records, and other information used to make the decision on your claim for benefits that you are appealing.

Beyond first-level appeals, you also have the right to request an External Review, Expedited Review, Voluntary Second-level Appeal, or request a review by the Ohio Department of Insurance. Please consult your Certificate of Coverage booklet for the detailed steps.

Q. My plan requires I get preauthorization for surgery. My physician told me that I need this surgery but my plan will not authorize it. What can I do?

A. First, have your doctor contact the MMO to discuss the situation. You and your doctor can provide Medical Mutual with the information to support your contention that the surgery should be authorized, and ask Medical Mutual to reconsider its decision.

If pre-authorization is requested for non-Participating Provider Option (PPO) Network Benefits, your physician must provide MMO with the following:

- The proposed treatment plan for the Covered Services.
- Name and location of the proposed non-PPO Network Provider.
- Copies of your medical records, including diagnostic reports.
- An explanation of why the Covered Services cannot be provided by a PPO Network Provider.

MMO's determination is final and conclusive.

Q. My health care provider is demanding payment up front prior to being submitted to the insurance company. What are my rights?

A. Contracting providers will generally not ask for money to be paid up front (except for office visit co-pays). Contracting providers have agreed to accept discounted pricing. By collecting the fee up front, they would have to reimburse the patient the difference between the Fee and the allowed amount. However, their contract does not exclude them from collecting any deductible/coinsurance that may be due them up front. MMO does not have contracts with dentists, but generally they will submit the claim then “balance bill” the member. If you go to a non-contracting provider, they can collect the entire amount up front since the employee would receive the payment for the claim and not the provider.

Q. Another plan has some extra services that I can’t get on my own plan. When is the next time I can change plans?

A. You can only change health care plans during the Open Enrollment period, which is usually held annually during the month of November.

Q. Generally, what events allow me to change my enrollment?

A. If you have individual coverage, you may change to 2-person or family coverage if you marry, or you or your spouse acquire an eligible dependent. A spouse and other dependents who become eligible by reason of marriage will be effective on the date of the marriage, but an application for coverage must be completed within 31 days of the marriage. A newborn child or adopted child will be covered at time of birth or adoption, but an application for coverage must still be received within 31 days of the event in order for coverage to continue beyond the first 31 days.

If you become divorced, a former spouse can be removed upon legal verification (i.e., Divorce Decree), unless a Medical Support Order requires the spouse to remain covered. Documentation will need to be submitted to Human Resources.

For health insurance changes resulting in individual(s) being removed (i.e., a dependent removed due to age limits or spouse divorced), the new deduction amount will take effect the first paycheck of the following month.

Otherwise, any other changes can only occur during the formal open enrollment period.

Q. What is the difference between Generic drug? Formulary? Non-Formulary?

A. The differences are defined in your Certificate of Coverage booklet as:

Generic – Prescription drug produced by more than one manufacturer. It is chemically the same as and usually costs less than the brand name prescription drug. Generic drugs have a \$7 deductible.

Formulary – Brand name prescription drug included in MMO’s list of preferred prescription drugs. Formulary drugs have a \$15.00 deductible, if no generic drug is available.

Non-Formulary – Brand name prescription drug not included in MMOs list of preferred prescription drugs. Non-formulary drugs have a \$25.00 deductible, if no generic drug is available.

It is important to note that if you purchase a Brand Name Formulary or Non-Formulary prescription drug, when a Generic drug is manufactured or available, you will be required to pay the Generic drug deductible of \$7 plus the difference between the cost of the Generic prescription drug and the cost of the Formulary or Non-formulary prescription drug for each prescription order obtained from a participating drug provider. If a Generic drug is not manufactured or is not available, you will simply pay the applicable deductible of \$15 (Formulary) or \$25 (Non-formulary).

If your prescription order is for a prescription drug available through mail order program, and you choose not to use the mail order program, you will pay a significantly greater amount for the prescription drug.

Keep in mind the importance of going to a Participating Drug Provider. Walgreens is no longer part of the Participating Drug Providers under the Super Med Plus plan. If you go to a non-participating drug provider, MMO will pay 75% of the lesser amount, minus the deductible plus any differences.

Q. Are the deductibles different if I participate in the Medco Mail Order Prescription Program?

A. If you purchase a Generic prescription drug, you will be required to pay a \$14 deductible for a 90-day supply; \$30 deductible for a Formulary drug; and \$50 deductible for a Non-formulary drug. Please be familiar with the Mail Order Program information in your Certificate of Coverage booklet or call Medco toll-free at 1-800-922-1557. .

Q. What questions should I ask my doctor or pharmacist about any medicine prescribed or recommended for me?

A. As a savvy health care consumer, always ask your doctor if a generic prescription drug is available. You will be responsible for the additional dollar amounts over and above the deductible for a formulary or non-formulary drug, if a generic drug is available.

Q. I had to pay a deductible for dental services. Shouldn't this be included in my medical deductible?

A. The dental benefit deductible is separate from the medical benefit deductible and represents a separate expense incurred and paid by you for Covered Dental Services before the Dental Plan starts to provide benefits. Please refer to the *Traditional Dental with Orthodontia Benefits Summary* Page for a listing of services which are fully covered and services which are subject to a deductible.

Q. How do I know if a Dentist is part of the DenteMax Network?

A. DenteMax is a preferred provider network of independent dentists who have accepted a set fee schedule when receiving payment for dental services. To find a participating dentist, please consult your DenteMax Traditional Dental Network Provider Director or call DenteMax at 1-800-752-1547 or go online to <http://www.MedMutual.com> to search for a participating dentist. You may still go to the dentist of your choice, but your out-of-pocket expenses may be more.

Q. Who is considered a Managed Vision Care Provider under the Commission's Vision Plan?

A. Employees may go to any of the following participating Managed Vision Care Providers: Target, Sears, Pearle Vision, J.C. Penneys as well as a number of independent eye doctors as listed in your SuperMed Vision Network Provider Directory.

Under the SuperMed Vision Plan, employees are entitled to one vision exam during every 12-month period and are responsible for the \$10 co-pay. The Plan covers the first \$115 toward frames per 24 months, with a 15% discount on frames over \$115. Employees may receive one pair of plastic lenses at no cost every 12-month period. Contact lenses are provided at no additional cost, if medically necessary; \$125 maximum for cosmetic and disposal lenses.

Q. What if I want to go to another provider for glasses or an examination?

A. You have the option of going to an Optometrist outside the SuperMed Vision Care Network. If you do so, your coverage will be significantly less:

- \$25 will be reimbursed toward cost of the exam.
- \$18 will be reimbursed toward the cost of frames.
- \$25 will be applied toward single vision lenses; \$35 for bifocals; \$52 for trifocals; \$52 toward progressive lenses; and \$62 toward lenticular lenses.
- \$210 will be reimbursed toward contact lenses per 12-month period, if medically necessary; \$125 will be reimbursed for contact lenses, if cosmetic or disposable.

CONTACT INFORMATION

For general inquiries or to receive provider booklets or summary plan descriptions, please contact Maggie Baldy at 440-234-2081, ext. 1112 or by email at mbaldy@ohioturnpike.org.

For specific inquiries regarding medical claim filings, hospital preadmission, prior approval for certain services and surgeries, please contact Medical Mutual at the number listed on your insurance card or refer to your Certificate of Coverage booklets.