MEDICAL MUTUAL
EMPLOYEE HEALTH INSURANCE

- IS AVAILABLE THROUGH THE ROSS-PIKE COUNTY EDUCATIONAL SERVICE DISTRICT TO **FULL TIME EMPLOYEES** (30+ HOURS)

- **OPEN ENROLLMENT** IS IN DECEMBER, WITH AN EFFECTIVE DATE OF JANUARY 1.

- HAS A SPOUSAL COORDINATION OF BENEFITS; IN ORDER FOR EMPLOYEES TO HAVE FAMILY MEDICAL COVERAGE FOR A SPOUSE, THE CRITERIA ON THE SPOUSAL COORDINATION OF BENEFITS FORM MUST BE MET. THE COMPLETED FORM MUST BE SUBMITTED WITH THE APPLICATION WHEN REQUESTING MEDICAL COVERAGE FOR AN EMPLOYEE'S SPOUSE.

- PAYROLL DEDUCTIONS FOR MEDICAL INSURANCE WILL BEGIN THE **MONTH PRIOR** TO THE EFFECTIVE DATE OF COVERAGE.

- EMPLOYEES THAT QUALIFY FOR HEALTH INSURANCE AND ELECT TO WAIVE COVERAGE **MUST COMPLETE, SIGN AND SUBMIT THE WAIVER OF COVERAGE FORM**

- PLEASE COMPLETE MEDICAL MUTUAL EMPLOYEE APPLICATION / CHANGE FORM AND **SUBMIT WITH ALL REQUIRED DOCUMENTATION (birth certificates and marriage license if requesting coverage for dependents and spouse) TO:**

ROSS-PIKE COUNTY ESD
475 WESTERN AVE, SUITE E
CHILLICOTHE, OHIO 45601
740-702-3123 (FAX)

SCHWENDEMAN AGENCY INC.

Ross Pike County ESD

Medical & Rx Benefit Overview

Effective: January 1, 2017

Carrier / Plan Design	Plan (D) Medical Mutual of Ohio HDHP - HSA Plan	
Benefits	In-Network	Out-of-Network
Annual Deductible (Ded)	**Deductibles are Embedded**	
Single	**$3,000**	**$6,000**
Family	**$6,000**	**$12,000**
Coinsurance (Coins)	**100%**	**60%**
Out-of-Pocket Maximum	Ded & Coins	Ded & Coins
Single	**$3,000**	**$12,000**
Family	**$6,000**	**$24,000**
Lifetime Maximum	Unlimited	Unlimited
Physician Office Visit		
Primary Care	Ded & Coins	Ded & Coins
Specialist	Ded & Coins	Ded & Coins
Preventative	100%	Ded & Coins
Laboratory & X-Ray	Ded & Coins	Ded & Coins
Hospital Services		
Inpatient Hospital Deductible	None	None
Inpatient Hospital	Ded & Coins	Ded & Coins
Outpatient Hospital	Ded & Coins	Ded & Coins
Emergency Services		
Urgent Care	Ded & Coins	Ded & Coins
Emergency Care - Emergency	Ded & Coins	Same as Network
Copay Waived if Admitted	NA	NA
Emergency Ambulance Services	Ded & Coins	Same as Network
Prescription Drugs		
Deductible	**See Medical Deductibles**	
OOP Maximum	**Included in Medical OOP**	
Retail		
Tier 1	**Ded then 100%**	NA
Tier 2	**Ded then 100%**	NA
Tier 3	**Ded then 100%**	NA
Tier 4	NA	NA
Mail Order		
Tier 1	**Ded then 100%**	NA
Tier 2	**Ded then 100%**	NA
Tier 3	**Ded then 100%**	NA
Tier 4	NA	NA

This is an overview of benefits. For exact benefits please refer to the SPD or certificate.

INSURANCE RATE EFFECTIVE JULY 1, 2018 - Ross Pike County ESD
Wellness Plan, SCB 7(D)

MEDICAL-Monthly	100%	Employee 20%	Employer 80%
SINGLE	$ 762.00	$ 152.40	$ 609.60
FAMILY	$ 1,744.00	$ 348.80	$ 1,395.20
MEDCIAL-Annual	100%	Employee 20%	Employer 80%
SINGLE	$ 9,144.00	$ 1,828.80	$ 7,315.20
FAMILY	$ 20,928.00	$ 4,185.60	$ 16,742.40

DENTAL-MO	100%	Employee 20%	Employer 80%
SINGLE	$ 30.00	$ 6.00	$ 24.00
FAMILY	$ 65.00	$ 13.00	$ 52.00
DENTAL-Annual	100%	Employee 20%	Employer 80%
SINGLE	$ 360.00	$ 72.00	$ 288.00
FAMILY	$ 780.00	$ 156.00	$ 624.00

VISION-MO	100%	Employee 20%	Employer 80%
SINGLE	$ 10.00	$ 2.00	$ 8.00
FAMILY	$ 15.00	$ 3.00	$ 12.00
VISION-Annual	100%	Employee 20%	Employer 80%
SINGLE	$ 120.00	$ 24.00	$ 96.00
FAMILY	$ 180.00	$ 36.00	$ 144.00

Health Savings Account Contrib.	Single	$ 1,000.00
	Family	$ 2,000.00

MEDICAL MUTUAL®

HMO Health Ohio®

Employee Application / Change Form

(For 51+ Groups Only) (PLEASE USE BALL POINT PEN)

SuperMed HMO®

☐ **New Enrollee Date of Hire**_____ ☐ **Re-hire Date**_____ ☐ **Coverage Change Date**_____

BASIC INFORMATION

GROUP NO.:	**SECTION NO.:**	**LEVEL OF BENEFITS:** ☐ Single ☐ Family ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Two Persons ☐ Medicare Supplemental	**EMPLOYMENT STATUS:** ☐ Active ☐ Retired ☐ COBRA

EMPLOYEE CLOCK NUMBER:	**EMPLOYEE DEPT. NO.:**	**PAYROLL LOCATION:**

CHANGES: ☐ Add Dependents due to:
☐ Marriage ☐ Birth ☐ Adoption
☐ Drop Dependents Due To:
☐ Divorce ☐ Death ☐ Other _____
☐ New Name
☐ New Address
☐ Change to Medicare Elig.
☐ Change Coverage
☐ Other _____

Date of Event Mo. ___ Day ___ Yr. ___

Cov. or Change Eff. Date Mo. ___ Day ___ Yr. ___

Last Name	First Name	M Initial	E-mail Address

Street Address	City	State	Zip	Phone No.

Employee Date of Birth Mo. Day Yr.	Sex ☐M ☐F	Tobacco User? ☐Y ☐N	Employee Social Security Number	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legal Separation	Date Married Mo. Day Yr.

Employer or Group Name	Date of Hire-Full Time Mo. Day Yr.	Job Title

Check Coverage Desired: ☐ **Health: Benefit Option or Product Desired** _____ ☐ Prescription Drug ☐ Dental ☐ Vision

Life: ☐ Basic Life: ☐ Basic AD&D ☐ Dependent Life ☐ Supplemental Life and/or AD&D ☐ Short-Term Disability ☐ Long-Term Disability

Class: _____ Earnings: $_____ ☐ Weekly ☐ Monthly ☐ Annual

For HMO and Point-of-service plans:

Primary Care Physician (PCP) Name _____ State_____ Current Patient? ☐ YES ☐ NO

PCP Name for Dependents (if different than above): _____

MEDICARE INFORMATION

Are you covered by Medicare? ☐ YES ☐ NO
If YES, Medicare No. _____ Effective Date: _____ ☐ Hemodialysis
Is your spouse covered by Medicare? ☐ YES ☐ NO
If YES, Medicare No. _____ Effective Date: _____ ☐ Hemodialysis

OTHER INSURANCE INFORMATION

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE? ☐ **YES** ☐ **NO**
IF YES, COMPLETE THE SECTION BELOW.

Name of Policy Holder	Name and Address of Other Insurance Co	Policy Number	Effective Date	Coverage Types	Work Status	Policy Type
			/ /	☐Medical ☐Dental ☐Hospital Only ☐Vision ☐Presc. Drug	☐ Active ☐ Retired	☐ Single ☐ Family
			/ /	☐Medical ☐Dental ☐Hospital Only ☐Vision ☐Presc. Drug	☐ Active ☐ Retired	☐ Single ☐ Family

What date did your most recent health insurance program become effective (check box if no prior/current coverage)?____/____/____ ☐ No coverage

What date did/will this health insurance program terminate (check box if no prior/current coverage)?____/____/____

DEPENDENT INFORMATION

Relationship	Birthdate	Sex	Tobacco User?	Last Name (only if different)	First Name	Soc. Sec. No.	Over Age Dependent Status
Spouse	Mo. Day Yr.	☐ M ☐ F	☐ Y ☐ N				
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐ M ☐ F	☐ Y ☐ N				☐ F/T Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐ M ☐ F	☐ Y ☐ N				☐ F/T Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐ M ☐ F	☐ Y ☐ N				☐ F/T Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐ M ☐ F	☐ Y ☐ N				☐ F/T Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability

1. Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application if relationship is marked other.

BENEFICIARY DESIGNATION

(For Employee Only: Must be completed if you have applied for Life or AD&D insurance). If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

Last Name	First Name	Date of Birth	Relationship	Benefit %
Primary:				
Primary:				
Contingent:				
Contingent:				

WAIVER

COMPLETE THE WAIVER SECTION BELOW ONLY if you do not want any coverage or want to waive some of the coverage options.

A. Waived coverages: I do not want (Check all that apply)

☐ Self: ☐ Health ☐ Drug ☐ Dental ☐ Vision through Medical Mutual® ☐ Life & Disability

☐ Dependent: ☐ Health ☐ Drug ☐ Dental ☐ Vision through Medical Mutual for the following spouse and/or dependent(s) only:

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Please indicate reason for waiving coverage:

☐ No coverage

☐ Employee/dependent has existing coverage. Insurance company name: _____

B. Terms and Declarations:

I understand that if I check any box in Question A of this Waiver, I am choosing not to have those persons covered under the health coverage designated, and any later. Application for enrollment and acceptance will be subject to all underwriting requirements.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may be able to enroll yourself or your dependents in this plan if: (1) you or your dependents lose eligibility for that other coverage or reach the plan's lifetime benefit maximum; or (2) the employer stops contributing towards you or your dependents's other coverage. However, you must request enrollment within 31 days after the applicable event occurs (other coverage ends, lifetime maximum is met, or employer's contribution ends). If you or your dependent either become eligible for premium assistance or lose eligibility for coverage under the State Children's Health Insurance Program (SCHIP), you will also be able to enroll in this plan. However, you must request enrollment within 60 days after such an event. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you will be able to enroll yourself and your dependents, provided thatyou request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

I have read and understand the above terms:

Current Employer: _____

Print Employee Name: _____ Employee Social Security No.: _____

Print Spouse Name: _____ Spouse Social Security No.: _____

Employee Signature: _____ Date: _____

WARNING: If you or your family members are covered by more than one healthcare plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

SIDE 1 – RCSEIC MEMBER COMPLETES THIS SIDE FIRST

RCSEIC HEALTH PLAN (RCSEIC-HP) COB QUESTIONNAIRE

(Documents of Spouse's Access to Employer Sponsored Medical Insurance)

- **All employees with Family Medical coverage MUST complete this form annually.**

RCSEIC-HP Member _____ SSN _____

Spouse's Name _____ SSN _____

*If you do not have a spouse, please put N/A by Spouse's Name and sign below.

The RCSEIC-HP COB (Coordination of Benefits) requires spouses of covered employees to join their employer's group or retiree health plan (on at least an Individual coverage basis) where such availability to coverage exists. Your spouse's claims will not be considered for payment until this form is completed and returned to our Treasurer.

Certain conditions will allow your spouse to be waived from this requirement.

Y = Yes N = No – Circle Answer (All questions must be answered)

Y N My spouse is self-employed and has access to health coverage but must pay 50% or more of the Premium cost for Individual coverage.

Y N My spouse is self-employed and does not currently have access to a group medical plan.

Y N My spouse works part-time. (Part-time is defined as LESS than 20 hours a week on average or on a seasonal basis)

Y N My spouse has access to the RCSEIC-HP plan through his/her school employer.

Y N My spouse is NOT employed and NOT retired.

Y N My spouse is retired, is not actively employed and is not eligible to enroll in any employer's retiree health plan. Answering "Yes" will indicate that your spouse does not have access to any retiree coverage other than Medicare. Answering "No" indicates your retired spouse is eligible to participate in a retiree plan. Your spouse must enroll in his/her own retiree plan. If a retiree plan is available, please have the employer complete Side 2 of this questionnaire.

The Plan will grandfather spouses who retired prior to 7/1/09 and who are not otherwise gainfully employed.

- If you answered "No" to all the above questions, your Spouse's employer must complete Side 2 of this questionnaire. Employee must read and sign the box below.
- If you answered "Yes" to any of the above questions, your spouse is waived from COB requirement for as long as the condition applies. Read and sign the box below and return this form to the business office. (see mailing address on Side 2) or attach to your enrollment form.

SIGNATURE REQUIREMENT – EMPLOYEE ACKNOWLEDGEMENT OF COB RESPONSIBILITY:

If my spouse's employment status changes in the future, I understand that I am responsible for completing an Enrollment Form and COB Questionnaire within 31 days of the employment status change. If your spouse is eligible for coverage through their employer and does not take that coverage, he/she is not eligible for coverage under the RCSEICHP plan. If an Employee or Dependent (or anyone acting on behalf of either) makes a false statement or withholds information, and as a result coverage is provided which would otherwise not have been, or claim which would other-wise not be paid is paid, the Plan has the right to: 1. Recover any amounts paid as a result of the misrepresentation and 2. Terminate coverage immediately, and 3. Recover damages, including legal fees, from the Employee or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided.

Employee Signature _____ Date _____

SIDE 2 – SPOUSE'S EMPLOYER COMPLETES THIS SIDE

RCSEICHP Member
If you answered "No" to all the questions on side 1, your Spouse's employer must complete side 2 of the questionnaire in order for your spouse's medical claims to be considered.

Spouse's Employer:
The RCSEICHP COB requires spouses of covered employees to join their employer's group health plan (on at least an individual coverage basis) where such availability to coverage exists. Please complete the box below in order for your employee's medical claims to be considered.

Y = Yes N = No - Circle Answer

Y N 1. Does your active employee have access to continuous employer sponsored health coverage through their employment by you?

Y N 2. Does your active employee work a minimum of 20 hours a week on average over a calendar 12-month period?

Y N 3. Is your active employee required to pay 50 percent or LESS of the total employer premium for their Individual/Single medical coverage?

Y N 4. Does your retired employee have access to retiree coverage other than Medicare?

The above responses are correct to the best of my knowledge.

_____ _____
Employer Representative Date

Phone Number_____Ext._____ Date of Open Enrollment_____

Company Name_____

Answering No to any questions requires supporting documentation on company letterhead be attached (i.e. work schedule, Plan Document, contribution amounts, etc.)

Answering YES to 1, 2 & 3 or YES to just 4 requires that your employee/retiree must be enrolled for primary coverage through your employer sponsored health plan on at least an Individual basis in order to remain an eligible dependent under the RCSEICHP plan. Please provide the information below.

Company Health Insurance/Payor/Carrier_____

Phone_____ Address_____

_____

Subscriber_____ Subscriber SS#_____

[ ] Single Coverage Effective Date_____

[ ] Family Coverage Effective Date_____
(Attach copy of enrollment form for COB purposes)

Direct inquiries and return form to:

Ross Pike County Educational Service District
Attn: Treasurer's Office
475 Western Ave., Suite E
Chillicothe, OH 45601

Ross-Pike Educational Service

If electing coverage for spouse/dependents, please submit copies of the following documents:
Spouse - marriage license
Dependents - birth certificates

Ross-Pike Educational Service District

475 Western Avenue ▪ Suite E
Chillicothe ▪ OH 45601
Phone: 740/702-3120 ▪ Fax: 740/702-3123

P.O. Box 578
Piketon ▪ OH 45661
Phone: 740/289-4171▪ Fax: 740/289-4542

FAMILY DECLARATION & DEPENDENT CERTIFICATION FOR INSURANCE COVERAGE

Your employer-sponsored health insurance is a valuable benefit, but it is also a costly one. It becomes more costly to you and your employer when ineligible dependents are covered. The dependent eligibility audit is to ensure that only eligible dependents are covered under your school district benefits. This will help us control costs and ensure enrollment files are accurate.

I CERTIFY THAT THE FOLLOWING DEPENDENTS ARE TRUE AND DOCUMENTS WERE PRESENTED FOR DEPENDENT VERIFICATION

Name________________________ **Relationship**__________ **Document Supplied**____________
dependent *Spouse/Child* *Marriage license/BirthCertificate*

Name________________________ **Relationship**__________ **Document Supplied**____________
dependent *Spouse/Child* *Marriage license/BirthCertificate*

Name________________________ **Relationship**__________ **Document Supplied**____________
dependent *Spouse/Child* *Marriage license/BirthCertificate*

Name________________________ **Relationship**__________ **Document Supplied**____________
dependent *Spouse/Child* *Marriage license/BirthCertificate*

Name________________________ **Relationship**__________ **Document Supplied**____________
dependent *Spouse/Child* *Marriage license/BirthCertificate*

Name________________________ **Relationship**__________ **Document Supplied**____________
dependent *Spouse/Child* *Marriage license/BirthCertificate*

Name________________________ **Relationship**__________ **Document Supplied**____________
dependent *Spouse/Child* *Marriage license/BirthCertificate*

____

Signature of Employee Presenting Documents **Date**

It will be my responsibility to advise my employer of any changes that would alter the above.

WAIVER OF PARTICIPATION

Employer: ROSS-PIKE COUNTY ESD

- I understand that my dependent children and I are eligible for major medical coverage and have an opportunity to purchase this coverage.

- I also understand that the individual mandate from Health Care Reform requires that almost all individuals must obtain minimum essential health coverage or potentially pay a tax.

At this time, after careful review, I elect not to enroll in the major medical coverage.

Employee Name: _____

Employee Signature: _____

Date: _____