2020 OSU HEALTH PLAN PROVIDER MANUAL

THE OHIO STATE UNIVERSITY

HEALTH PLAN

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I. Background and Overview

The Ohio State University Health Plan (OSUHP) is the administrator of the medical plans for faculty, staff and dependents of The Ohio State University. The medical plans are self- funded through Ohio State and OSUHP is not a commercial health insurance company. OSUHP administers benefits for approximately 68, 000 members in all 88 Ohio counties.

A. Affiliate Plans

OSUHP network is also utilized by affiliates. Note that OSUHP does not administer the benefits for its affiliates. Providers will need to contact the administrator listed on the patient's card for claims and benefit questions.

i. Ohio PPO Connect

Ohio PPO Connect is a provider-owned, Ohio-based network with a local and regional approach to health care delivery. It brings the experience and expertise of the following networks to provide statewide coverage: Ohio Health Choice, Quality Care Partners, and The OSU Health Plan. The PPO network can be accessed by OSUHP members for services rendered outside of Franklin County. Ohio PPO Connect covers over 150, 000 members and all PPO connect members will have the following logo on their card:

ii. **OSU Student Health Plan**

The plan administrator for the OSU Student Health Plan is HealthSmart Benefit Solutions, Inc. underwritten by UnitedHealth Care Student Resources. To verify eligibility/benefits, you can contact HealthSmart Benefit Solutions, Inc. at (844) 206-0374. See member's ID card for claims and prior authorization contact information.

II. Benefits and Covered Services

A. Benefit Plans

OSUHP offers four benefit packages: Prime Care Advantage (PCA), Prime Care Choice, Prime Care Connect and Out of Area. The Prime Care Advantage, Prime Care Choice and Prime Care Connect plan has been reorganized into the Premier and Standard Network. Members may continue to see providers in any network at any time. All plans have a calendar-year benefit period with no pre-existing condition clause.

PRIME CARE ADVANTAGE

COST OF CARE

PRIME CARE ADVANTAGE	IN NETWORK	OUT OF NETWORK
ANNUAL DEDUCTIBLE	INDIVIDUAL - $450 FAMILY - $900	NOT APPLICABLE
OUT-OF-POCKET MAXIMUM	INDIVIDUAL - $2,600 FAMILY - $5,200	NOT APPLICABLE

COVERED SERVICES

PRIME CARE ADVANTAGE	PREMIER NETWORK	STANDARD NETWORK
PREVENTATIVE CARE	PLAN PAYS 100%	PLAN PAYS 100%
PRIMARY CARE	PLAN PAYS 100%	PLAN PAYS 70% AFTER DEDUCTIBLE
BEHAVIORAL HEALTH **INPATIENT** **OUTPATIENT**	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 80% NO DEDUCTIBLE
ALL OTHER OFFICE VISITS **SPECIALIST:** **ALL OTHER VISITS:**	PLAN PAYS 80% NO DEDUCTIBLE PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE PLAN PAYS 70% AFTER DEDUCTIBLE
EMERGENCY CARE	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 80% AFTER DEDUCTIBLE
URGENT CARE **IN OHIO:** **OUTSIDE OHIO:**	PLAN PAYS 80% NO DEDUCTIBLE	PLAN PAYS 80% NO DEDUCTIBLE
INPATIENT	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE
OUTPATIENT SURGERY	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE
LAB AND X-RAY	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE
MEDICAL EQUIPMENT	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE
CONVENIENT CLINIC CARE	PLAN PAYS 100%	PLAN PAYS 100%

PRIME CARE CHOICE

COST OF CARE

PRIME CARE CHOICE	IN NETWORK	OUT OF NETWORK
ANNUAL DEDUCTIBLE	INDIVIDUAL - $950 FAMILY - $1,900	INDIVIDUAL- $1,900 FAMILY - $3,800
OUT-OF-POCKET MAXIMUM	INDIVIDUAL - $3,750 FAMILY - $7,500	INDIVIDUAL - $2,600 FAMILY - $5,200

COVERED SERVICES

PRIME CARE CHOICE	PREMIER NETWORK	STANDARD NETWORK	OUT-OF-NETWORK
PREVENTATIVE CARE	PLAN PAYS 100%	PLAN PAYS 100%	PLAN PAYS 60% AFTER DEDUCTIBLE
PRIMARY CARE	PLAN PAYS 100%	PLAN PAYS 70% AFTER DEDUCTIBLE	PLAN PAYS 60% AFTER DEDUCTIBLE
BEHAVIORAL HEALTH INPATIENT OUTPATIENT	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 60% AFTER DEDUCTIBLE
ALL OTHER OFFICE VISITS SPECIALIST: ALL OTHER VISITS:	PLAN PAYS 80% NO DEDUCTIBLE PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE PLAN PAYS 70% AFTER DEDUCTIBLE	PLAN PAYS 60% AFTER DEDUCTIBLE
EMERGENCY CARE	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 80% AFTER DEDUCTIBLE

URGENT CARE IN OHIO: OUTSIDE OHIO:	PLAN PAYS 80% NO DEDUCTIBLE		PLAN PAYS 60% AFTER DEDUCTIBLE
INPATIENT	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE	PLAN PAYS 60% AFTER DEDUCTIBLE
OUTPATIENT SURGERY	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE	PLAN PAYS 60% AFTER DEDUCTIBLE
LAB AND X-RAY	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE	PLAN PAYS 60% AFTER DEDUCTIBLE
MEDICAL EQUIPMENT	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE	PLAN PAYS 60% AFTER DEDUCTIBLE
CONVENIENT CLINIC CARE	PLAN PAYS 100%	PLAN PAYS 100%	PLAN PAYS 60% AFTER DEDUCTIBLE

PRIME CARE CONNECT

COST OF CARE

PRIME CARE CONNECT	IN NETWORK
ANNUAL DEDUCTIBLE	INDIVIDUAL - $450 FAMILY - $900
OUT-OF-POCKET MAXIMUM	INDIVIDUAL - $2,600 FAMILY - $5,200

COVERED SERVICES

PRIME CARE ADVANTAGE	PREMIER NETWORK	STANDARD NETWORK
PREVENTATIVE CARE	PLAN PAYS 100%	PLAN PAYS 100%
PRIMARY CARE	PLAN PAYS 100%	PLAN PAYS 70% AFTER DEDUCTIBLE
BEHAVIORAL HEALTH INPATIENT OUTPATIENT	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 80% NO DEDUCTIBLE
ALL OTHER OFFICE VISITS SPECIALIST: ALL OTHER VISITS:	PLAN PAYS 80% NO DEDUCTIBLE PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE PLAN PAYS 70% AFTER DEDUCTIBLE
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INPATIENT	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE
OUTPATIENT SURGERY	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE
LAB AND X-RAY	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE
MEDICAL EQUIPMENT	PLAN PAYS 80% AFTER DEDUCTIBLE	PLAN PAYS 70% AFTER DEDUCTIBLE
CONVENIENT CLINIC CARE	PLAN PAYS 100%	PLAN PAYS 100%

Pharmacy

	Prime Care Advantage Prime Care Choice Out of Area		Prime Care Connect	
Annual Deductible	Individual $50 Family $100		No Deductible	
Annual Out- of Pocket Maximum	Individual $2,500 Family $5,000		Individual $2,000 Family $4,000	
Feature	**Retail Pharmacy**	**Home Delivery**	**Retail Pharmacy**	**Home Delivery**
Supply Limitation	30 Day Supply	90 Day Supply	30 Day Supply	90 Day Supply
Tier Level	Preferred Pharmacy	Non-Preferred Pharmacy	Home Delivery or Retail 90 Pharmacy	Preferred Pharmacy
Generic Drug	$10 copay	$20 copay	$25 copay	$8 copay
Formulary Brand Drug	30% Coinsurance Up to $100	35% Coinsurance Up to $110	30% Coinsurance Up to $250	30% Coinsurance Up to $40

Value Based Drug Plan

	Prime Care Advantage Prime Care Choice		Prime Care Connect	
	Preferred Pharmacy	Home Delivery or Retail90 Pharmacy	Preferred Pharmacy	Home Delivery or Retail90 Pharmacy
Supply Limitations	30 Day Supply	90-Day Supply	30 Day Supply	90-Day Supply
Generic Drug	$0	$0	$0	$0
Formulary Brand Drug	15% coinsurance, up to $50	15% coinsurance, up to $125	15% coinsurance, up to $20	15% coinsurance, up to $50
Non Formulary Brand Drug	50% coinsurance, no maximum	50% coinsurance, no maximum	50% coinsurance, no maximum	50% coinsurance, no maximum

B. Covered Services and Limitations

i. Acupuncture

Acupuncture is used to alleviate pain and to treat certain physical conditions. Acupuncture services and chiropractic care are limited to a combined maximum benefit of $2,000 per plan year.

ii. Ambulance

Ambulance service is transportation by a vehicle designed, equipped and used only to transport the sick and injured, when medically necessary:

- From your home, scene of accident or medical emergency to a hospital.
- Between hospitals.
- Between a hospital and an extended care facility.
- From a hospital or an extended care facility to your home.
- From your home to an extended care facility, or provider office
- Surface trips must be to the closest local facility that can give covered services appropriate for your condition. If none are available, you are covered for trips to the closest such facility outside your local area.
- Air transportation is covered when such transportation is medically necessary because of a life-threatening injury or sickness and availability of specialty care. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a hospital for inpatient care.

iii. **Behavioral Health**

All inpatient behavioral (mental) health services require prior authorization, unless admitted directly from the emergency room (notification to OSU Health Plan of hospital admission is then required within one business day) and include the assessment and treatment of mental and/or psychological disorders and substance abuse. Behavioral (mental) health services for the care and treatment of mental illness are covered on an inpatient or outpatient basis. Substance abuse services for the care and treatment of alcoholism and drug addiction are also covered on an inpatient or outpatient basis. The following services are covered on an inpatient or outpatient basis:

- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Intensive outpatient behavioral health
- Family counseling and counseling with family members to assist in diagnosis and treatment, including marriage counseling
- Convulsive therapy includes electroshock treatment or convulsive drug therapy

A physician, mental health provider, hospital, specialized hospital, alcoholism treatment facility, or community mental health facility may provide behavioral (mental) health and substance abuse services.

iv. **Chiropractic Care**

Chiropractic care is dedicated to the detection and correction of spinal displacement to eliminate interference that can adversely affect health. Chiropractic care and acupuncture services are limited to a combined maximum benefit of $2,000 per plan year.

v. **Convenient Care Clinic**

A Convenient Care Clinic is a walk-in health care clinic located in a retail store, supermarket or pharmacy that treats uncomplicated minor illnesses, injuries or conditions not serious enough for urgent or emergent care. These facilities are staffed with nurse practitioners and physician assistants who collaborate with physicians.

vi. **Dental Services**

• Expenses for dental work are covered if they are for prompt repair of an injury to the jaw, sound natural teeth, mouth, or face, which are required as a result of an accident.

• Dental services are limited to the initial treatment of the injury that is rendered within 72 hours of the injury. Injury as a result of chewing or biting is not considered an accidental injury.

vii. **Emergency Care**

Emergency care is the service or treatment provided in the outpatient emergency department of a hospital or other provider within 72 hours of the onset of the emergency medical condition. An emergency medical condition is defined as a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of a body organ or part.

If a covered person is admitted to a hospital for an emergency care admission, notice of the admission must be provided to OSUHP as soon as possible after the admission, generally within one business day. The hospital, admitting physician, covered person, or friend/partner/family member of the covered person may give notice to OSUHP.

viii. **Extended Care Facility Service (Skilled Nursing Facility)**

Covered services in an extended care facility are the same as those shown in the Covered Services – Hospitalization Services and Medical Services, Inpatient sections. Refer to your plan's Schedule of Benefits, Extended Care Facility Services, for coverage details.

- Extended care facility services are covered for up to 60 days per plan year.
- Prior authorization is required before receipt of these services.
- Services must be medically necessary as a continuation of treatment for the condition for which you were hospitalized.

ix. **Genetic Counseling/BRCA**

The U.S. Preventive Services Task Force (USPSTF) recommends a "B" rating to "screen women who have family members with breast, ovarian, tubal or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing." There is no cost to the member for these services. All genetic testing services require prior authorizations.

x. **Hearing Aids and Ear Molds**

Coverage is provided for hearing aids and ear molds that are required to improve pure tone hearing ability for causes other than injury to the ear. The total maximum benefit is $1,200 every four plan years.

For dependents up to age 12, replacement ear molds that are medically necessary due to growth are covered and are not subject to the $1,200 maximum benefit.

xi. **Home Health Care Services**

Home Health may be provided on a part-time basis in the member's home as a medically necessary alternative to inpatient care. A home health care provider must provide the services according to a physician-prescribed course of treatment that has been prior authorized.

Covered services include skilled nursing services, diagnostic services and therapy services. Benefits are not provided for a nurse who usually lives in the home or is a member of the immediate family.

xii. **Hospice**

A medical care program providing a coordinated set of services rendered at home, in outpatient settings, or in institutional settings for covered persons suffering from a condition that has a terminal prognosis. A hospice must have an interdisciplinary group of personnel that includes at least one physician and one Registered Nurse (RN), and it must maintain standards of the National Hospice Organization (NHO) and applicable state licensing requirements. Covered services include, but are not limited to, room and board, nursing care, respite care, physical/occupational/respiratory therapy and bereavement counseling.

xiii. **Hospitalization Services**

The following hospitalization services are covered:

- Room and board in a semi-private room containing two or more beds, including meals, special diets and nursing services, other than private duty nursing services. Coverage includes a bed in a special care unit approved by OSUHP.

- Oral surgery, including the extraction of teeth, if hospitalization is medically necessary to safeguard the covered person's life or health due to a specific non-dental organic impairment. For these services to be covered, your physician must receive prior authorization.

  Ancillary services, such as:

  - Operating, delivery and treatment rooms and equipment
  - Prescribed drugs
  - Anesthesia, anesthesia supplies and services given by an employee of the facility — Medical and surgical dressings, supplies, casts and splints
  - Blood and blood services
  - Diagnostic services
  - Radiation therapy, intravenous chemotherapy, kidney dialysis, respiratory therapy, physical therapy (as defined below), occupational therapy (as defined below) and speech therapy (as defined below).

  - **Note:** All hospitalizations require prior authorization, unless admitted directly from the emergency room (notice of the admission must be provided to OSU Health Plan as soon as possible after the admission)

xiv. **Human Organ Transplants**

A human organ transplant is a human heart, heart-lung, liver, kidney, bone marrow or pancreas transplant. Coverage will be provided for all covered services as described. Expenses related to the acquisition of a human organ, if donor's primary insurance does not cover donor expenses. Acquisition includes the preparation, transportation and storage of a human organ. In order to receive benefits for Human Organ Transplants, you must contact OSUHP when you learn you are a candidate for transplant surgery.

Prior authorization will only be granted if the human organ transplant is medically necessary. No coverage will be provided for services or supplies that are considered by OSUHP to be experimental / investigative or that are related to a transplant surgery for which prior authorization was not obtained.

xv. **Infertility Treatment**

In order to receive benefits for infertility treatment, an obstetrician or gynecologist (OB/GYN) or endocrinologist must diagnose the infertility. In addition, coverage is limited to you and your spouse. All infertility

treatments are subject to a separate annual deductible. There is a separate lifetime maximum for infertility services. Any prescription medications included in this treatment are applied to the lifetime maximum. Expenses for infertility treatment do not apply toward the annual out-of-pocket maximum. Requires prior authorization and specific exclusions apply.

xvi. **Maternity Services**

Coverage for inpatient and outpatient maternity services includes all covered services listed under the Hospitalization Services, Medical Services-Inpatient, Medical and Surgical Supplies and Outpatient Services sections of this manual. Statement of Rights under the Newborns' and Mothers' Health Protection Act:

- Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier.

- Under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
- In addition, a plan or issuer may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).
- However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact OSUHP.

xvii. **Medical Equipment**

The rental or purchase of medical equipment is covered when prescribed by a physician. Rental costs must not be more than the purchase price. The equipment must serve only a medical purpose and be able to withstand repeated use. Expenses over $2,000 require prior authorization.

xviii. **Medical Services – Inpatient**

The following medical services, when performed by a physician, are covered on an inpatient basis:

- Care and treatment while you are confined in a medical facility.
- One physician visit per day.
- Consultation by another physician when requested by your physician. Staff consultations required by hospital rules are excluded from coverage.
- Care by two or more physicians during one hospital stay when your condition requires the skills of separate physicians.
- Dental services that are required as a result of injury to the jaws, sound natural teeth, mouth, or face.

xix. **Medical and Surgical Supplies – Outpatient**

- Syringes, needles, oxygen, surgical dressings, splints and other similar items that serve only a medical purpose are covered. Covered services do not include items usually stocked in the home for general use, such as adhesive bandages, thermometers and petroleum jelly.
- Medical supplies, equipment and appliances must be rented or purchased by an agency or provider approved by OSU Health Plan.
- Expenses over $2,000 require prior authorization

xx. **Medications**

- Covered pharmacy benefit services are subject to various exclusions, restrictions and limitations.
- Pharmacy benefits that require prior authorization must be obtained prior to coverage.
- Federal legend drugs which are medications that require a prescription under federal law and are approved for general use by the Federal Drug Administration (FDA).
- Injectable insulin that does not require a prescription is considered to be a covered drug.
- Covered over-the-counter medications require a prescription for coverage
- Additional details can be found in the specific plan detain or by contacting our pharmacy benefit manager, Express Scripts

xxi. **Newborn Care**

- Coverage for a newborn infant as described in this section is provided only as a covered person under two-person or family coverage.
- To have the services covered, you must add the newborn as a covered dependent under your medical plan in accordance with the requirements outlined in the General Plan Provisions – Change in Coverage Due to a Qualifying Status Change section of this manual.

- If single coverage is already in place prior to the birth of the newborn infant, then you must elect employee + child(ren) coverage and enroll the newborn infant.
- If employee + spouse coverage is already in place prior to the birth of the newborn infant, then you must elect family coverage and enroll the newborn infant.
- If family or employee + child(ren) coverage is already in place prior to the birth of the newborn infant, you are still required to enroll the newborn infant.

Coverage includes:

- Routine nursery care of a newborn infant.
- Inpatient visits to examine a newborn. A physician other than the physician who performed the obstetrical delivery must do the examination.

xxii. **Nutritional Services**

Nutritional services are services focused on food/nutrient intake or eating patterns. They can be provided by a licensed and registered dietician, physician, certified diabetic educator, or within an approved structured program. These services are appropriate when there is a condition or treatment that is directly influenced by food and nutrient intake such as diabetes, a malabsorption disorder such as celiac disease, an eating disorder, or obesity.

xxiii. **Occupational Therapy**

Occupational therapy is the treatment rendered on an inpatient or outpatient basis as a part of a physical medicine and rehabilitation program to improve functional impairments. It is considered medically necessary only if the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational and vocational therapies (such as hobbies, art and crafts).

All outpatient physical therapy and occupational therapy services are limited to a combined maximum of 45 visits per plan year.

xxiv. **Outpatient Services**

The following services are covered on an outpatient basis:

• Blood and blood services, if provided and billed by a hospital or other facility.

• Diagnostic services including laboratory services.

• Home and office visits to examine, diagnose, or treat an injury or sickness.

• Outpatient surgical services and supplies; other outpatient visits to examine, diagnose or treat an injury or sickness, including emergency care and the administration of allergy injections.

• Pre-admission tests and studies required for a scheduled admission as an inpatient.

• Radiation therapy, inhalation therapy, intravenous chemotherapy, kidney dialysis and physical therapy. Occupational, physical and speech therapy services must be rendered by a licensed therapist.

xxv. **Pervasive Development Disorder (PDD)**

Treatment for the diagnosis of Pervasive Developmental Disorder (PDD) Spectrum including Autism is covered by when medical necessity criteria are met. Coverage includes the following:

- Up to 20 hours per week of therapeutic aide services until age 21, if criteria are met.
- Professional services provided by a licensed mental health provider – Refer to Behavioral Health Services, Mental Health and Substance Abuse, Outpatient section in each specific plan's Schedule of Benefits.
- Speech therapy – Refer to the Speech Therapy, Outpatient section of the schedule of benefits
- Physical therapy – Refer to the Physical Therapy and Occupational Therapy, Outpatient section in each specific plan's Schedule of Benefits.

- Occupational therapy – Refer to the Occupational Therapy and Physical Therapy, Outpatient section in each specific plan's Schedule of Benefits.

xxvi. **Physical Therapy**

Physical therapy is treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment.

Such treatment must be given to relieve pain, restore maximum function and to prevent disability following disease, injury, or loss of body part.

Treatment must be for acute conditions where rehabilitation potential exists and the skills of a physician or other professional are required. All outpatient physical therapy and occupational therapy services are limited to a combined maximum of 45 visits per plan year.

xxvii. **Prosthetic Appliances**

Purchase, fitting, needed adjustment, repairs and replacements of prosthetic devices and supplies that:

- Replace all or part of a missing body organ and its adjoining tissues.
- Replace all or part of the function of a permanently useless or malfunctioning body organ.

Note: Expenses over $2,000 require prior authorization.

xxviii. **Radiology**

Radiology is the examination of the inner structure and parts of the body using X-rays or other penetrating radiation.

xxix. **Speech Therapy**

Speech therapy is the active treatment for improvement of an organic medical or developmental condition causing speech impairment.

Treatment must be post-operative or for the convalescent stage of an active illness or disease.

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time. All outpatient speech therapy services are limited to a maximum benefit of 20 visits per plan year.

xxx. **Surgical Services**

Surgery performed by a physician is covered on an inpatient or outpatient basis. Prior authorization is required before receipt of inpatient surgical services that include:

- Administration of anesthesia by a physician or other professional who is not the surgeon or assistant at surgery.
- Multiple surgical procedures when a physician performs more than one surgical procedure during the same operative session, the surgeon's bill will indicate the major or primary procedure performed and any secondary procedure(s).
- If two or more surgeries were performed during the same operative session, the following guidelines are normally used to determine the allowable expense for the claim:
- 100% of UCR paid for the first or primary procedure;
- 50% of UCR paid for the second and each additional procedure. Some procedures are considered "incidental," such as in the case of the removal of the appendix during other abdominal surgery. In this case, UCR would not normally consider any charges for the appendectomy.
- Reconstructive surgery to restore bodily function. Coverage is limited to medical conditions caused by disease, injury, or birth defects. Reconstructive surgery does not include any surgery that is specifically identified as an exclusion or to correct cosmetic surgery. Refer to the Medical Prior Authorization Guide available online at **osuhealthplan.com/forms-and-downloads** to determine the need for prior authorization.

xxxi. **Temporomandibular Disorder (TMD)**

TMD is a disease of dysfunction of the joint linking the jawbone and skull and the muscles, nerves and other tissues related to the joint. TMD covered services include diagnostic services, orthotic or orthopedic devices, adjustments to orthotic or orthopedic devices and therapeutic injection of medication into the TMD. There is a $3,000 maximum lifetime benefit for non-surgical procedures. Surgical procedures for the treatment of TMD are subject to the Surgical Services and Schedule of Benefits for your medical plan.

- No coverage is provided for crowns or for orthodontia (braces): these services may be covered under your dental care plan.
- Appliances/orthotic devices require prior authorization.

xxxii. **Tobacco Cessation Program**

Tobacco cessation services are covered through the university medical plans. Services are paid at 100%. Over-the-counter nicotine replacement therapy (NRT) and prescription cessation medications (e.g., Chantix) are paid at 100% through the Prescription Drug Program. See the Prescription Drug Program section. A prescription must be obtained from a physician or nurse practitioner for all tobacco cessation products. Free cessation services can be obtained through Health Coaching at OSU Health Plan by calling 614-292-4700.

xxxiii. **Urgent Care**

Urgent Care services are different than emergency medical services. An urgent condition is not life threatening, but may cause serious medical problems if not promptly treated. Urgent care is defined by the need to treat an unforeseen condition that requires immediate medical treatment for acute pain, acute infection, or protection of public health.

xxxiv. **Weight Loss Surgery and Related Services**

- Weight Management Programs include gastric bypass, gastric banding, gastric reduction and medically necessary skin excisions that are the direct result of significant weight loss.
- All services are subject to OSUHP guidelines available at https://osuhealthplan.com/forms-and-downloads (see Weight Loss Surgery Policy) and require prior authorization.

xxxv. **Weight Management Programs**

- Hospital-based/physician-directed programs are reimbursed at 50% up to $1,000 per plan year.
- Weight Watchers TM OnlinePlus and the Meetings Program are reimbursed at 50%. The reimbursement is applied to the month-to-month membership. Membership can be canceled at any time. For more information, or to join, visit **go.osu.edu/weightwatchers**.
- Expenses for Weight Management Programs are excluded from the annual out-of-pocket maximum

xxxvi. **Women's Health and Cancer Rights Act (WHCRA) of 1998 Notice**

As required by the Women's Health and Cancer Rights Act of 1998, the Ohio State plans provide coverage for reconstructive surgery and related services following a mastectomy. Specifically, the benefits include:

- Coverage for all stages of reconstructive surgery of the breast on which a mastectomy has been performed.
- Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for prostheses and physical complications through all stages of a mastectomy, including lymphedemia
- Treatment will be in a manner that is determined in consultation with the attending physician and patient.

- All terms and conditions (including annual deductibles and coinsurance) of your medical plan apply to this coverage. Contact OSUHP for more information.

III. Claims

a. Claim submission

OSUHP utilizes Trustmark as the third-party administrator that processes and pays claims for all Ohio State medical plans. All claims (medical and behavioral health services) can be submitted to Trustmark by mail or electronically. Trustmark accepts the following claim forms:

- CMS 1500 - AMA universal claim form also known as the National Standard Format (NSF) CMS Forms List
- CMS 1450 - UB-04 (for hospitals)

Providers must bill Trustmark for services with the most current coding available using HIPAA-compliant transaction and code sets. Claims must be legible and the information must be located in the appropriate fields on the claim form. Therefore, illegible claims and claims lacking required information will be denied as incomplete.

Claims mailing address:
Trustmark
P.O. Box 2310
Mt. Clemens, MI 48046

b. Provider Address

Both accurate remit and physical addresses are required to process claims. For office based claims, network status is based on the service location billed by the provider. If this location is not on the claim or does not match what address we have on file the claim will be processed as non-network provider and denied. For any address changes, fill out a provider update form.

Timely filing

i. **Original Claims:**

Claims for covered services must be received by Trustmark no later than 12 months from the date of service. Claims submitted after the filing limit will be denied

ii. **Claim resubmissions**

Claim appeals and corrected claims must be submitted no later than 12 months from the date of the original remittance advice. Claims resubmitted after this date will not be considered. For detail on submitting claim appeals or corrections, see section E.

iii. **COB Claims**

If OSUHP is a secondary plan, claims must be received no later than 12 months from the date of the primary remittance advice. Claims received after this date will be denied.

IV. Claims Editing

OSUHP has a pre-payment auditing process to identify frequent correct coding billing errors including but not limited to bundling and unbundling coding errors, duplicate claims, and global billing. Coding edits are based on Current Procedural Terminology (CPT), industry standard National Correct Code Initiative (NCCI) policy and guidelines and industry payment rules and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB). The National Correct Coding Initiative (NCCI) developed by CMS helps promote national correct coding methodologies for ensuring that claims are coded appropriately according to state and federal coding guidelines. The coding policies developed are based on:

- Coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual;
- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practice.

V. Claim Resubmissions

i. Corrected Claims

Corrected claims need to be submitted directly to Trustmark. For institutional claims, the UB 04 claim will need to be submitted with a bill type if XX7 to replace the original claim and XX8 to void/cancel the original claim. For professional claims, the claims will need to be submitted through the original submission process marked as a corrected claim.

ii. Claim Appeals

Claim appeals may be submitted on behalf of an OSUHP member (no member signature required), or the member may submit an appeal. Appeals (non-adverse benefit determination appeals) must be submitted to Trustmark within 12 months of receipt of the explanation of benefits (EOB). A written letter of appeal along with all supporting documentation should be sent to Trustmark at:

ATTN: Appeals Department
P.O Box 2310
Mt. Clemens, MI 48046

If the denial is overturned, the claim will be reprocessed. If you disagree with the decision you can submit a claim reconsideration form found at https://osuhealthplan.com/ to OSUHealthPlanPR@osumc.edu

VI. Coordination of Benefits (COB)

COB affects benefits in the following manner when you are covered by more than one benefit plan:

- When this medical plan is primary, Trustmark will authorize the payment of benefits on behalf of the university without regard to any other contract.
- If the total benefits for covered services to which you would be entitled as described in this booklet and under all other benefit plans exceed the covered services you receive, then the benefits provided will be determined according to this provision.
- When this medical plan is secondary, the following process will be followed. The primary plan pays benefits first. The primary plan will ignore the fact that the member is covered under a secondary plan and will pay the full eligible benefit. The secondary plan pays next by following these steps:

  The secondary plan will first calculate the plan benefits.
- The secondary plan will subtract the amount paid by the primary plan.
- The remaining difference, if any, will be paid by the secondary plan.
- When both this medical plan, paying as secondary and the primary plan have a preferred provider arrangement, payment will be made up to the preferred provider allowance available to the primary plan.
- When the primary plan payment exceeds the secondary plan's payment, the secondary plan will provide no additional benefit.
    - When this medical plan is secondary, it will never pay more than it would if it were the primary plan.

VII. Balance Billing

Contracted providers may not balance bill a member for the difference between the total billed charges and the plan allowed amount. If a provider receives a reduction in pay due to failure to obtain a prior authorization timely, the provider may not bill the member for the reduction.

A. Overpayment Refunds

In the event OSUHP finds an overpayment on a claim or must recoup money, a letter requesting the refund may be mailed to the provider. Details regarding the overpayment as well as appeal rights will be listed on the letter. OSUHP will seek recovery from the provider by offsetting future payments.

B. ERA/EFT

OSUHP offers electronic fund transfers (EFT) and electronic remittance advices (ERA) through ECHO Health Inc. To sign up for either of these services fill out the authorized and guarantee agreement for automated clearing house (ACH) authority and fax it to (440) 835-3511. In order to view the ERA's you will need to register for the ECHO portal at www.providerpayments.com.

VIII. Contracting and Credentialing

Contracting with OSUHP is a separate process from credentialing. Participation in our network requires an executed contract and approved credentialing status.

a. Initial Contracting

In order to become a contracted provider with OSUHP, providers must fill out the network request form.This form can be found at https://osuhealthplan.com and faxed to (614) 292-1166 or sent via email to OSUHealthPlanPR@osumc.edu.

b. Adding/terming providers and demographic changes

In order to avoid claim denials, OSUHP will need to be updated timely on all demographic changes for your practice. In order to do so, providers must fill out the Provider Information Form (PIF) found at https://osuhealthplan.com.

- If you are changing the group name and/or the remit address, include an updated W9 with the PIF.
- If adding a new provider to the practice, include a current malpractice face sheet along with PIF.
- If a provider is changing their legal name due to marriage or divorce you need to include the request on company letterhead with the effective date of the name change.
- If you are changing Tax ID numbers or starting a new practice, you will need to go through the initial contracting process again. Send a network request form to the provider network services department at OSUHealthPlanPR@osumc.edu.

c. Credentialing

To comply with the guidelines established by the National Committee for Quality Assurance (NCQA), providers must be fully credentialed before our members can see them. Claims will process as non-network until the provider's credentialing is complete. OSUHP does not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age or sexual orientation, or on type of procedure or patient (i.e., Medicaid) in which the practitioner specializes.

i. Initial Credentialing

If you have a CAQH number complete the CAQH Provider Data Form. You will need to give OSUHP permission to review. If you do not have a CAQH number, go to http://www.caqh.com to request a CAQH number and fill out the information. You will need to give permission to OSUHP to review.

ii. Re-credentialing

All providers will be re-credentialed every three years. Make sure your CAQH is up to date. CAQH must be attested every 120 days.

IX. Referrals

a. In Network Referrals

OSUHP does not require members to obtain referrals for services. However, some providers may require a referral to see a member/patient. When providing a referral for an OSUHP member, you must refer the member to another provider within the OSUHP network. Any consult from or other means of communication between you as the referring physician and the chosen consulting physician/provider is acceptable. It is not necessary to send a copy of the referral to the OSUHP. In Franklin County, the network hospitals are the OSU Wexner Medical Center, University Hospital East, James Cancer Hospital and Solove Research Institute, Richard M. Ross Heart Hospital, and Nationwide Children's Hospital. See www.osuhealthplan.com for a listing of all participating hospitals.

b. Out of Network Referrals

If Prime Care Advantage / Prime Care Connect members are referred to or self-refer to non-participating hospitals or specialists, there is no coverage. The only exception is emergency services. If service cannot be provided in-network, service must be prior authorized through Medical Case Management at OSUHP. To verify whether a provider is participating in the OSUHP network, contact us at 614-292- 4700 / 800-678-6269.

c. OSU ConsultLine

If you are interested in referring a patient to or talking with a physician at The Ohio State University Hospitals or The James Cancer Hospital, call the OSU ConsultLine at 800-824-8236.

X. Prior authorization and Med Necessity Review

a. Medical Necessity

For a service to be considered medically necessary a covered service must:

- Be rendered in connection with an injury or sickness;

- Be consistent with the diagnosis and treatment of your condition;
- Be in accordance with the standards of good medical practice;
- Not be for your convenience or your physician's convenience and
- Not be considered experimental or investigational

b. Inpatient Admission Review

Utilization Review is required for all inpatient admissions including elective admissions, extended care facilities, hospice care, medical rehabilitation, surgical, and urgent/emergent admissions. For urgent or emergent admissions notification with medical documentation is required to be submitted to the Medical Management Department within 48 hours of admission. For elective admissions clinical documentation must be sent in at least 10 days prior to the admission. You can contact the Medical Management Department at 614-292-4700 or 800-678- 6269. Supporting clinical documentation can be faxed to 614-292-2667.

When faxing provider must include:

- Procedure requested;
- Diagnosis;
- Physician and Facility;
- Date of Service; and
- Medical record documentation to support medical necessity (such as patient history, progress notes, conservative treatment(s) failed, etc.).

c. Outpatient Observation Policy

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests.

Hospitals may bill for patients who are directly referred to the hospital for outpatient observation services. A direct referral occurs when a physician in the community refers a patient to the hospital for outpatient observation, bypassing the clinic or emergency department (ED) visit. Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly referred for observation services.

d. Coverage

When a physician orders that a patient receive observation care, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient receiving observation services may improve and be released, or be admitted as an inpatient.

All hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by OSUHP. In most circumstances, observation services are supportive and ancillary to the other separately payable services provided to a patient.

i. **Criteria**

Outpatient observation services are covered for up to 48 hours and may include:

1. Use of a bed within a hospital for the purpose of observing the member's condition

2. Periodic monitoring by the hospital's staff to evaluate an outpatient's condition and/or determine the need for a possible admission to the hospital as an inpatient

Outpatient observation services should not be used for routine diagnostic services and outpatient surgery/procedures.

If the physician or health care professional is uncertain if an inpatient admission is appropriate, then the physician or health care professional should consider admitting the patient for observation. For coverage to be appropriate for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. Any case exceeding 48 hours of observation care will require medical director review.

ii. <u>Limitations</u>

The following outpatient observation services are not covered as the services are not medically reasonable or necessary:

1. Services that are not reasonable or necessary

2. Outpatient observation services that are provided only for the convenience if the member or his/her family or physician. (e.g., following an uncomplicated treatment or a procedure, physician busy when patient is physically ready for discharge, patient awaiting placement in a long term care facility)

3. Services that are covered under a medically appropriate inpatient admission, or services that are part of another service, such as postoperative monitoring during a standard recovery period, (e.g., 4- 6 hours), which should be billed as recovery room services. Similarly, in case of patients who furnished prior to the testing and recovery afterwards are included in the payment for those diagnostic services. Observation should not be billed concurrently with the therapeutic services such as chemotherapy.
4. Standing orders for observation following surgery.

e. <u>Prior Authorization</u>

Some services /procedures/treatments require prior authorization.

Prior authorization must be requested at minimum 10 days prior to rendering services. If prior authorization, where indicated, is not obtained from OSUHP, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to $1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket limit.

Prior authorization (see the Medical Prior Authorization Guide online at **osuhealthplan.com/forms-and-downloads**) is a determination made by OSU Health Plan of the medical necessity of an inpatient hospital setting and the appropriate length of stay. Authorization must be obtained for every hospital admission. Prior authorization for emergency admissions must be obtained within one business day.

- If the covered person sees a network provider, the network provider is responsible for obtaining the prior authorization.
- If the covered person is enrolled in a non-network medical plan or uses an out-of-network provider, it is his/her responsibility to obtain prior authorization and to inform the providers that he/she is enrolled in a medical plan that has prior authorization requirements.
  • In order for OSU Health Plan to conduct a pre-admission review, it must be:
    - Provided with information necessary to make a decision as to the medical necessity of the admission.
    - Informed no later than 10 business days prior to the admission to the hospital, unless the admission is an urgent care admission.
- The hospital, admitting physician, covered person, or any person on the patient's behalf can give notice to OSU Health Plan of a hospital admission.

Services that require prior authorization include but are not limited to the following:

Services Requiring Prior Authorization	
Behavioral Health	Home Health Care Inpatient Hospitalization Residential Treatment rTMS
Diagnostic	Genetic Testing
Medical	Extended Care Facility Inpatient Hospitalization Home Health Care Hospice Hyperbaric Oxygen Skilled Nursing Facility
Medical Supplies	DME, Medical Supplies, Orthotics & Prosthetics over $2,000
Medications (Medical Benefit)	Certain oral, inhalation and subcutaneous medications are excluded from the medical benefit. Please submit these medications through the pharmacy benefit for outpatient dispensing and any prior authorization requirements. Certain IM/IV drugs also restricted to pharmacy benefit. In addition, medication on the medical benefit are reviewed for appropriate site for care. Refer to the specific code list and Site of Care policy available on the OSU Health Plan website. Please call OSU Health Plan or Express Scripts for additional information. Types of medications that may require prior authorization or be excluded from the medical benefit include, but are not limited to: Autologous Chondrocyte Implantation Blood Conditions Botulinum Toxin CAR T-cell Therapy Chemotherapy Enzyme Replacement Therapy Growth Deficiency Hemophilia Hepatitis C Virus Hereditary Angioedema Hypercholesterolemia Hypogonadism Immune Deficiency Infertility Inflammatory Conditions Iron Deficiency Anemia Miscellaneous Multiple Sclerosis Ophthalmic

	Oral Mucositis, Saliva Agents and Stomatitis Products Osteoarthritis Osteoporosis Pulmonary Hypertension Respiratory Sleep Disorders Weight Management
Surgery and Procedures	Abdominoplasty/ Panniculectomy Abortion Back Pain - Invasive Procedures Blepharoplasty/ Ptosis Repair Breast Reconstruction/ Repair Bronchial Thermoplasty Breast Reduction Surgery and Gynecomastia Surgery Chemical Peel & Dermabrasion Cosmetic Procedures Frenectomy Gender Reassignment Hernia Repair Infertility Treatment Neurostimulators Orthognathic Surgery Pectus Excavatum & Poland Syndrome Procedures for Obstructive Sleep Apnea Rhinoplasty Skin Procedures (Also see Cosmetic section) Sterilization Reversal Varicose Veins Weight Loss Surgery
Other	Dental Experimental services, such as Temporary Codes and Unlisted Codes

f. Pharmacy

Express Scripts, Inc. (ESI) is the Pharmacy Benefit Manager (PBM) for the Ohio State medical plans. Providers can contact Express Scripts, Inc. at 800-417-8164. The OSUHP formulary can be found under the forms and downloads section of the provider website at https://osuhealthplan.com.

XI. Quality Improvement

OSUHP will begin aligning with the current structure and key processes of the health care industry in order to focus on quality of care and overall health of its membership.

a. Access Standards

OSUHP has adopted access guidelines by specialty type. All participating Primary Care Physicians (PCP) and Specialists are expected to adhere to these access standards for appointment scheduling.

- Appointment Scheduling: to be done at initial call or within same business day call back by office
- Telephone Access: 24-hour accessibility, phones busy less than 50% of office operating hours.
- Hold time no more than two minutes, phone answered within forty-five seconds, abandonment rate of 5% or less.
- Waiting Room Wait Time: No more than 20 minutes if arrival within five minutes of scheduled time
- Exam Room Wait Time: No more than 10 minutes
- Office hours – Must maintain office hours at least four full days weekly with arrangements for 24-hour coverage.
- (For group practices, the presence of one participating physician at least four days weekly will fulfill this requirement.)

New Patient Appointments	
PCP	Within 4 weeks
Specialist	Within 4 weeks
Behavioral Health	Within 4 weeks
Routine Follow-Up Appointments	
PCP	Within 2-3 weeks
Specialist	Within 4 weeks
GYN Annual Visit	Within 8-12 weeks
Urgent Care	Within 24 hours
Emergent Care	Immediately

b. Feedback

To ensure that all service complaints are monitored and addressed in a timely manner, all member and provider complaints will be forwarded to the Quality Improvement (QI) Manager for research and review. Complaints may involve internal service issues or service by an OSUHP third-party administrator (TPA). All complaints should be in writing on a Member Concern Record, which can found on our website or through Customer Service and will be handled by the Quality Improvement Department.

Service complaints received from a member will have a thirty (30) day turnaround time frame from receipt. Service complaints will be acknowledged in five (5) business days of receipt.

c. **Your Plan for Health (YPFH)**

Your Plan for Health (YP4H) is The Ohio State University's approach to fostering a culture of well-being and optimal performance. YP4H provides programs and resources to empower benefits-eligible faculty, staff, or family members to pursue a life of health and wellness.

The focus of the initiative is to help members reach the healthiest state possible by offering programs and incentives for identifying and acting on health conditions, promoting smart, cost-efficient choices based on individual needs, and taking control of health-care spending.

The cornerstone of this initiative is the Personalized Health and Well-Being Assessment (PHA), a questionnaire that, coupled with a biometric health screening numbers, establishes a health baseline and sets a direction for employees to pursue health, wellness, and disease management. Additional services include educational programming, health fairs, flu vaccinations, personal health coaching, and care coordination.

i. Annual Biometric Health Screenings

Complimentary on-campus screenings are provided by registered nurses on site at The Ohio State University. Members may also obtain their values from the PCP. Measurements include blood pressure, A1C, body mass index, HDL and total cholesterol. The member will receive a copy of their values and are counseled on ways to improve their numbers via nutrition and physical activity and stress management. Members are encouraged to share this information with their PCP and are connected to various services available to them at Ohio State, such as health coaching and fitness center discounts.

ii. Personal Health and Well-Being Assessment

Members complete an assessment to help identify personalized health and wellness goals based on the information they submit. Team and individual challenges are available to help members track their progress toward those goals—and have fun while doing it—from weight loss to increased daily water consumption. Mobile device integration is also available to track healthy behaviors on the go even easier.

Members will be able to connect apps like FitBit® Tracker or Swimsense® to their YP4H account to track challenges and incentives through their smartphone or tablet.

iii. Educational Programming

Each month, a variety of educational programs are offered to members. A wide range of topics are presented within the areas of weight management, stress management, physical activity, nutrition, and related areas.

Presenters offer valuable health and wellness information via webinars and face-to-face classes. Members can access this information via the osuhealthplan.com website, where they also have access to the archived webinars.

iv. Personal Health Coaching Services

OSUHP offers Personal Health Coaching for Ohio State benefits eligible faculty, staff, and their adult dependents as a complimentary service for Your Plan for Health. This confidential and voluntary service is designed to assist members in achieving personal wellness. With the support of a Personal Health Coach, members can work on their personal health and wellness goals such as weight management, nutrition, physical activity, tobacco cessation, and stress management. We have coaches with a range of clinical and behavioral backgrounds, including exercise physiologists, social workers, health educators, tobacco cessation specialists, and dietitians. Each coach is trained in all areas to promote a holistic approach to meeting personalized health needs.

Program participants appreciate the support, awareness, and accountability with their personal health coach that helps keep them on track for reaching their optimal health. OSUHP health coaches also link members to resources on campus and in the local community for added support.

v. Disease Management/Care Coordination

Those who live with asthma, diabetes, heart disease, and chronic obstructive pulmonary disease can gain support from a team of health professionals (including pharmacists, nurses, health coaches and behavioral health professionals) to help with management of their condition and lifestyle changes. Care Coordinators provide education, guidance, and resources available to support personal health and wellness goals. Care Coordination is available to faculty and staff and their dependents that are enrolled in an eligible Ohio State medical plan and are identified for one of these programs based on an analysis of medical and prescription drug claims.

vi. Buckeye Baby

The Buckeye Baby program, offered by OSUHP as a service of Your Plan for Health, offers a variety of resources to help members and their family on their new journey. For questions, call (614) 292- 4700, extension 0 or email osuhpbuckeyebaby@osumc.edu.

1. Web-Based Prenatal Series - The program consists of four live webinar-based discussions that review different pregnancy-related topics. During each session, you will be able to ask questions and share ideas with other pregnant moms as well as with a nurse and dietitian. Individual telephonic sessions are also available as needed.
2. Lactation Support offers: Lactation consultations covered at 100%, OSU Buckeyes for Breastfeeding Club, Complimentary double electric breast pump.
3. Buckeyes for Breastfeeding Club: Staffed by nurse and physician lactation counselors, these groups are for OSUHP moms who want to give and receive support on their breastfeeding journey.

d. Ohio State Employee Assistance Program (OSU EAP)

The OSU EAP is designed to provide rapid access to a variety of support and information regarding stressful life situations for employees and their dependents/family. In addition to rapid access to face-to-face counseling, the OSU EAP also can help with a variety of other issues that affect everyone daily. All services are provided without cost in a confidential environment. Counselors are available in almost all Ohio Counties.

i. All benefit-eligible faculty, staff, and their dependents and family members can call anytime and speak with a licensed mental health counselor for quick assistance with personal or work/life related problems. Eligible dependents include parents, parents-in-law, and anyone living within the faculty or staff member's household. Call (800) 678-6265 for help.

ii. Robust Web-Based Information, Self-Assessment and Resources

The OSU EAP webpage (www.osuhealthplan.com/OhioStateEAP) contains a large selection of informative articles, resource lists or search assistance for services and a variety of tools to do self-assessments. This can be accessed in total confidentiality. Employees and their families can use the EAP for help with:

1. Childcare and Eldercare Resources
2. Depression
3. Family Conflict
4. Financial Consultation
5. Grief and Loss
6. Identify Theft Support
7. Legal Consultation
8. Stress and Anxiety
9. Substance Abuse
10. Work Challenges
11. Managerial Support

XII. Contact Us

a. Address and Contact info

Main Office Location OSU Health Plan Inc. 700 Ackerman Road, Suite 1007 Columbus, OH 43202
Phone: (614) 292-4700 ▪ (800) 678-6269
Fax: (614) 292-2667 (Medical Management)
Office hours: 7:30AM – 5:00PM, Monday-Friday
Website: www.osuhealthplan.com

b. Trustmark

Columbus Office Location 655 Metro Place South Suite 500 Dublin, OH 43017
Phone: 614-336-9604▪ 800-282-3920
Website: myTrustmarkBenefits.com

c. Provider Relations

OSUHP's provider relations department oversees provider network, contracting, credentialing, servicing, and educating providers. Contact our department in the following instances:

- If office has changes regarding Tax Identification Number, address, phone number, etc.
- If additional providers join practice or if providers leave;
- Questions on fees, contracts, or credentialing; and
- Any other questions from staff or physicians.

Email:OSUHealthPlanPR@osumc.edu

Fax: (614) 292-1166

SAMPLE MEMBER ID CARD