

Ohio Chamber Health Benefit Program Broker Transition Guide

A Step-by-Step Resource for Moving Groups to Medical Mutual

This guide provides brokers with the information needed to help Ohio Chamber employer groups successfully transition from their previous carrier to Medical Mutual. It covers the most important conversion topics to discuss with employers and employees, including plan participant access, continuation of care, provider search tools, COBRA administration and prescription transition planning.

Transition Area	Broker Action	Recommended Timing
Offer acceptance and implementation initiation	Collect the completed employer application, updated Medical Mutual Membership census and signed rate offering to confirm acceptance and begin implementation.	Immediately after the group confirms intent to move forward.
Medical Mutual Employer Dashboard (MED) and My Health Plan access	Confirm the group understands where employers and plan participants will access Medical Mutual tools and sign up for EFT, access ID cards, claims, benefits and plan resources.	Before effective date and after group implementation is complete.
Transitional care waivers	Identify plan participants in active treatment and guide them through the continuation of care request process.	As early as possible and prior to the conversion date to allow for collecting necessary information from the plan participants. This should be submitted with or shortly after group implementation. Waivers cannot be approved until after implementation is complete. Medical Mutual anticipates receiving historical clinical information in terms of preauthorization and will share updates to this process.
SuperMed Plus Network search	Help plan participants verify physicians, facilities and hospitals before scheduling care.	Prior to enrollment decisions and before the first post-conversion appointment.
COBRA services	Determine whether COBRA or state continuation services are needed, and coordinate setup requirements.	Prior to group implementation.

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Transition Area	Broker Action	Recommended Timing
HSA Administration	Determine whether HSA banking administration services are required, and coordinate setup requirements. Reminder that there are no additional fees for banking with our authorized vendor.	Prior to group implementation.
Prescription transition to Express Scripts	Review current prescriptions, mail-order needs, prior authorizations, specialty medications and refill timing.	30–45 days before effective date, when possible.
Paper claims and claim forms	Direct plan participants to locate claim forms on Medical Mutual's Member Forms page or through My Health Plan. Complete the correct form, attach itemized bills and mail paper claims to the address shown on the form or ID card.	As needed, after services are received and group implementation is complete.
Renewal Effective Date Reminder	Groups whose original renewal date was January 1 will receive a 12-month rate offer. Groups with a May 1 original renewal date will renew again May 1, 2028. Groups with a September 1 original renewal date will renew Sept. 1, 2027.	This should be covered with your client at the point of accepting the proposed rating offer prior to implementation.
Open Enrollment Reminders	Due to this special transition, groups will experience a special open enrollment from Dec. 1, 2026, through Dec. 31, 2026, for a January 1 effective date. They will also have the month of January to submit open enrollment changes for a Feb. 1, 2027, effective date. Thereafter, open enrollment will occur either in the month prior to the renewal effective date or in the renewal month, depending on when coverage is intended to take effect.	This should be covered with your client at the point of accepting the proposed rating offer prior to implementation.
Enrollment Audit	Prior to paying their first invoice and preferably prior to Jan. 1, 2027, all groups should audit their enrollment via the Medical Mutual Employer Dashboard (MED) to ensure it is complete and correct.	After implementation is complete, and prior to paying the first billing - preferably prior to Jan. 1, 2027.

1. Accepting the Offer and Initiating Implementation

Once a group confirms its intent to move forward with Medical Mutual, the broker should collect the required acceptance materials so the group can be moved into implementation without delay. The employer application, updated Medical Mutual Membership census, signed rate offering and COBRA Waiver should be reviewed for completion and consistency before submission. Reference the transition checklist [here](#).

Implementation timing reminder: Please allow to 5 to 10 business days after complete and accurate implementation materials are received for group and enrollment information to be available in Medical Mutual's systems. This conversion occurs during Medical Mutual's peak implementation period. Although dedicated resources will be assigned to support the transition and expedite processing where possible, brokers should plan accordingly and encourage employer groups to make decisions as early as possible.

- **Employer application:** Ensure the application is fully completed, signed where required and aligned with the group's legal name, contribution approach, eligibility rules and selected plan option. Signing the employer application will also serve as acknowledgement of the participation agreement, plan documents and underwriting regulations.
- **Updated census:** Provide the most current employee and dependent census available including enrollment elections, waiver information, dependent details and any other information required to validate rates and eligibility. The Medical Mutual [membership census template](#) is readily available on My Broker Link. Be sure to follow the instructions outlined on the "sold" tab of the membership census template.

As there will likely be a gap between implementation and January 1, groups will need to access MED to make any enrollment updates during that period. This will help ensure that all employees who require access are enrolled, and that terminated employees are removed as needed. Please note that enrollment exceptions can only be processed retroactively for up to 60 days.

- **Signed rate offering:** Include the accepted rate offering signed by the employer or authorized group representative to document the group's acceptance of the Medical Mutual proposal. Please ensure that both rates and plan titles are included.
- **COBRA waiver:** if applicable
- **Implementation handoff:** Allow at least 5–10 business days for group and enrollment loading once completed materials are submitted.
- **HSA Banking:** If the group intends to elect Medical Mutual's HSA banking solution, include the required banking paperwork with the group implementation materials. A link to the necessary paperwork and a link to directions outlining what is required should be provided with the implementation packet. Remind groups that banking fees are included in premium when using Medical Mutual's authorized banking solution. Maintaining an outside banking solution may cause the group to incur additional fees.
 - [HSA setup form](#)
 - [HSA EFT Authorization](#)
 - [HSA /HRA Contract](#)

2. Accessing MED and My Health Plan

Brokers should explain the distinction between employer-facing and member-facing access points. MED should be positioned as the employer or broker administrative resource, while My Health Plan is the secure member website used after Medical Mutual ID cards are issued.

- Confirm the group contact knows how to access MED and who to contact for administrative support. Please be certain to include the group's administrative contact on the employer application.
- Advise plan participants to register for My Health Plan and download the MedMutual mobile app after receiving their Medical Mutual ID card.
- Encourage plan participants to use My Health Plan to view benefits, claims, ID cards, provider information and plan resources.
- Remind groups that access timing may depend on enrollment completion, eligibility loading and ID card generation.

3. Applying for Transitional Care Waivers

Medical Mutual is working with the Ohio Chamber to obtain clinical data to ensure a smooth transition of previously pre-authorized care. Transitional care waivers may also allow plan participants to continue an active course of treatment with a current provider for a limited period when the transition to Medical Mutual could otherwise interrupt care. Brokers should encourage groups to identify impacted plan participants early and submit requests with the implementation paperwork or soon thereafter. Ask the employer to identify employees or dependents currently receiving ongoing treatment, scheduled procedures, pregnancy-related care, behavioral health care, oncology care, complex specialty care, or other time-sensitive services.

- Collect the required plan participants, provider, diagnosis, treatment and appointment information needed for review.
- Submit the waiver request through the designated Medical Mutual process or contact channel provided during implementation.
- Set expectations that approval is not automatic and is subject to Medical Mutual review, plan provisions, clinical criteria and applicable regulatory requirements.
- Instruct plan participants to keep upcoming appointments scheduled while the request is reviewed, but to verify coverage and network status before receiving services.
- Please have providers fill out the [Continuation of Care](#) form, as necessary, and return as indicated.

4. Searching the Medical Mutual SuperMed Plus Network

- Use the Medical Mutual [Find a Provider tool](#) to look up physicians, specialists, hospitals and facilities.
- Search by provider name, specialty, location, county or facility name.
- Confirm that the provider participates in the applicable SuperMed Plus or SuperMed PPO network tied to the group's plan.
- Advise plan participants to call the provider before an appointment to confirm they are still in network and accepting new patients.
- Remind plan participants that hospital-based providers may have different network participation than the facility itself.

5. Setting Up COBRA Services, if Needed

- Beginning Jan. 1, 2027, The Ohio Chamber Health Benefit Program will follow the Plan documents and Federal Guidelines for COBRA and State Continuation eligibility. COBRA and State Continuation eligibility will be based on group size.
- Medical Mutual will grandfather the participants that have already elected COBRA (regardless of group size). If you currently have a COBRA Beneficiary where the employer is not subject to COBRA (fewer than 20 employees), they may remain on the plan until the continuation period ends. Groups that have fewer than 20 employees must self-administer COBRA beginning Jan. 1, 2027, or they can stay with their current COBRA vendor (may incur fees).
- Confirm whether the employer is subject to federal COBRA, Ohio continuation or another continuation requirement.
- Identify the current COBRA administrator, if any, and determine whether administration will remain with that vendor or transition to a new service arrangement.
- Gather required employer information, group eligibility data, current qualified beneficiaries, rates, plan options and effective dates.
- Coordinate communication timing so notices, premium billing and enrollment records are accurate at conversion.
- Confirm how COBRA participants will receive Medical Mutual ID cards and access My Health Plan.
- Remaining with an outside COBRA administrator may result in additional incurred costs.

6. Transitioning Prescriptions to Express Scripts

Prescription transition planning should begin before the effective date, especially for plan participants using maintenance medications, mail-order prescriptions, specialty drugs, infusion therapy or medications requiring prior authorization. Brokers should encourage groups to review pharmacy communications carefully and *avoid waiting until the first refill is due*.

- Encourage plan participants to refill eligible prescriptions before the effective date if their medication supply may run out during the transition.
- Confirm whether maintenance medications should move to Express Scripts mail order or remain at a participating retail pharmacy.
- Review any medications that may require prior authorization, step therapy, quantity limits or specialty pharmacy coordination.
- Encourage plan participants to have prescription details available, including medication name, dosage, prescribing physician, pharmacy and refill schedule.
- For specialty medications, begin the transition process early to reduce the risk of therapy disruption.
- For more information on Medical Mutual's prescription drug resources, as well as paper claims and claim forms, please visit the resource page [here](#).
- Most participating providers will submit claims directly to Medical Mutual. If a provider does not submit a claim, or if the member is billed directly and needs to request reimbursement, the plan participants should complete the appropriate Medical Mutual claim form and include the required itemized documentation.

- **Where to locate forms:** Plan participants can access claim forms through Medical Mutual's Member Forms page or by signing in to My Health Plan. Brokers should remind members to use the form that matches the type of claim being submitted, such as medical, dental, vision or prescription drug claim forms.
- **What to include:** Submit a completed claim form with itemized bills or receipts that include the provider name and address, patient name, date of service, diagnosis or procedure information when applicable, services provided and amounts charged.
- **Where to submit paper medical claims:** Plan participants should mail completed paper claims to the address listed on the back of their Medical Mutual ID card or as instructed on the applicable claim form. Medical Mutual claim form materials commonly reference Medical Mutual, P.O. Box 6018, Cleveland, OH 44101-1018. Members should always verify the correct mailing address on their ID card or the specific form before submitting.
- **Broker reminder:** Claims should be submitted promptly and within the timeframe stated in the member's plan materials or Evidence of Coverage. Incomplete forms or missing itemized bills may delay processing.

Suggested Broker Communication Timeline

- **As early as possible:** Encourage groups to make their final decision early due to high effective-date volume and the time needed to complete implementation.
- **Immediately after offer acceptance:** Collect the employer application, updated census and signed rate offering. Confirm the requested effective date and implementation contacts.
- **5–10 business days after complete materials are received:** Allow time for the group and enrollment to be loaded and accessible. Medical Mutual will have dedicated staff supporting this implementation and will expedite processing where possible, but brokers should build in sufficient lead time.
- **45–60 days before effective date:** Begin group education, identify plan participants in active treatment, review COBRA needs and collect prescription transition concerns.
- **30 days before effective date:** Confirm enrollment data, share provider search instructions, begin transitional care waiver submissions, prepare pharmacy transition messaging and direct plan participants to where claim forms can be found if paper claims are needed.
- **15 days before effective date:** Confirm ID card timing, remind plan participants to register for My Health Plan after cards are issued and validate open care, prescription or paper-claim questions.
- **Effective date and first 30 days:** Monitor plan participants questions, provider access concerns, waiver decisions, COBRA participant setup, pharmacy refill issues and any plan participants questions about submitting paper claims.

Broker Talking Points

- This conversion is an opportunity to reset plan participants education and help employees understand where to go for care, benefits, claims and pharmacy information.
- Provider participation should be verified before services are received, even when a provider appears in an online directory.
- Plan participants in active treatment should be identified early, so continuation-of-care options can be reviewed before disruption occurs.
- Prescription planning is especially important for specialty medications, controlled refill schedules, prior authorizations and mail-order users.
- Plan participants should be reminded that most providers submit claims directly, but claim forms are available through Medical Mutual's Member Forms page or My Health Plan if a paper claim is needed.
- COBRA and continuation of administration should be addressed during implementation.
- Brokers should confirm whether the group intends to elect Medical Mutual's HSA banking solution and include the required banking paperwork and directions with the implementation materials. Banking fees are included in premium when the group uses Medical Mutual's authorized banking solution. Maintaining an outside banking arrangement may result in additional fees for the group.

Early decision message: Because January 1 is a high-volume effective date, brokers should encourage groups to accept their coverage and submit all required materials by December 1 to help ensure ID cards are received by January 1. Early decisions give Medical Mutual the best opportunity to load the group, process enrollment and resolve open issues before the effective date.

If you have any questions related to the information or materials within this transition guide, please reach out to your Medical Mutual Account Executive or Account Administrator. To help ensure the smoothest transition possible, we encourage groups to make enrollment decisions as early as possible.