THE OHIO STATE UNIVERSITY

Office of Human Resources Benefits
The Ohio State University
1590 N. High St., Suite 300
Columbus, OH 43201

At the request of The Ohio State University, Office of Human Resources, Luminare Health is sending this letter to gather information about any other medical plan coverage your dependent(s) may have. You can expect to receive this request for information from us annually, as coverage situations change and we need to ensure our records are updated accordingly. The coverage information that you provide allows us to properly determine benefit payments under the university's medical plan Coordination of Benefit rules.

Please provide the information listed in the enclosed Request for Additional Coverage Information to Luminare Health within 30 days of letter receipt.

Thank you for your assistance!

To make this process easier, you can respond online by logging in to myLuminareHealth.com with your user name and password. There you will find a menu option "My Correspondence", which will list any letters requiring your response.

Respond online at: **myLuminareHealth.com** – look for the "My Correspondence" tab once logged in.

Respond via phone: 866.442.8257

Respond via fax: 586.416.3001

Respond via mail: Luminare Health
P.O. Box 4386
Clinton, IA 52733

It is important you respond to this request, even if your covered dependents do not have additional coverage, to ensure your claims can be processed in a timely and accurate manner.

If you should have any questions, contact Customer Service with Luminare Health at 1-866-442-8257.

Please provide the following information for any other medical plan under which your dependents are covered.

OSU Employee's Name:
Trustmark Health Benefits Employee's Unique Identifier Number:

Other Medical Coverage Details (report Medicare on the next page): If no other coverage exists, please indicate "Not Applicable" below, then sign and date the last page of this form. If there is more than one other coverage, please include a separate piece of paper with the following information.

Name of Other Insurance Provider: ____________________

Other Insurance Provider's Address: ____________________

Policy Holder Name: ____________________

Policy Holder's Social Security Number or Plan Member/ID Number: ____________________

Policy Holder's Date of Birth: ____________________

Policy/Plan Number: ____________________

Effective Date of Other Coverage: ____________________

This coverage is provided by:
(check only one)

- o OSU Employee's Previous Employer (COBRA)
- o Spouse's Current Employer
- o Spouse's Previous Employer (COBRA)
- o OSU Employee's Ex-Spouse
- o Spouse's Ex-Spouse
- o Medicaid or other Government Plan
- o TRICARE Active Duty

Names of individual(s) covered by the above plan and also covered by an Ohio State medical plan:

Name of person covered	***Relationship to the policyholder with other coverage***	***Birth date***

<u>Dependent Child Details</u>: Complete this section if you have indicated your dependent child(ren) have medical coverage through a former spouse.

Does a divorce decree or child custody agreement establish which parent is responsible for providing medical coverage? ○ Yes ○ No

If yes, who is the parent responsible for providing primary coverage? ______________________

If no, who has primary custody of the dependent children? ______________________

<u>Medicare Coverage Details</u>: Complete this section if you have coverage provided through Medicare.

Name of individual with Medicare coverage? ______________________

Effective date of Medicare coverage? ______________________

What is the reason for the Medicare coverage? ○ Working Aged (over 65) ○ End-Stage Renal Disease ○ Under 65, Totally Disabled

Medicare Number: ______________________

If your dependents have Medicare coverage, please include a copy of your Medicare card when responding to this letter.

Thank you for completing the above information!
Please remember to sign this form before returning or log into myLuminareHealth.com to respond online!

I understand that, as an Ohio State medical plan member, I have the responsibility to provide, when requested, complete and factual information to Luminare Health about any other medical coverage or insurance benefits that I may have, as specified in the Medical Plan Detail Document outlining program provisions for the university's medical plans. I further understand that any person who, knowingly and with intent to defraud, applies for coverage or files a claim containing any materially false information is guilty of fraud, which is subject to disciplinary action, up to and including termination of benefits and/or employment.

I certify that the above information is true and complete to the best of my knowledge

Signature: ____

Please include any supporting documentation when mailing this form; if you respond online you can upload your supporting documentation with your online response.

Please respond to Luminare Health, within 30 days of receiving this notice.

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