

Ohio Basic and Standard Plans for Indemnity Carriers (pages 1-6) and for Health Insuring Corporations (pages 7 -13).

**OHIO INDIVIDUAL INDEMNITY OHC PLANS**  
Schedule of Benefits

<u>BENEFIT</u>	<u>BASIC</u>	<u>STANDARD</u>	<u>PPO IN-NETWORK</u>	<u>PPO OUT-NETWORK</u>
Calendar Year Deductible	\$ 1,000	\$ 750	\$ 750	\$ 750
Family Limit on Deductible	NONE	NONE	NONE	NONE
Emergency Room Deductible <sup>①</sup>	\$ 75	\$ 75	\$ 75	\$ 75
Coinsurance (Plan/Insured)	<u>50/50</u>	<u>70/30</u>	<u>80/20</u>	<u>60/40</u>
Individual Out of Pocket Maximum <sup>②</sup>	\$5,000	\$5,000	\$3,000 <sup>③</sup>	\$5,000 <sup>③</sup>
Family Out of Pocket	NONE	NONE	NONE	NONE
Maternity and Routine Nursery Care Benefits <sup>④</sup>	NONE	\$3,000	\$3,000	\$3,000
Calendar Year Maximum <sup>⑤</sup>	\$50,000	N/A	N/A	N/A
Lifetime Maximum <sup>⑤</sup>	N/A	\$1,000,000	\$1,000,000	\$1,000,000

① Emergency Room Deductible is waived if admitted to the hospital. This deductible is in addition to and will not be counted toward the Calendar Year Deductible.  
 ② Individual out of pocket maximum is in addition to the Calendar Year Deductible.  
 ③ In Network-and Out-Network coinsurance limits accumulate separately to the out of pocket maximum and are in addition to the Calendar Year Deductible.  
 ④ Basic plan maternity and routine nursery care benefits are limited only to complications of pregnancy. Maternity and routine nursery care benefits for a normal delivery are limited to \$3,000 per occurrence in both the standard and PPO plans. Complications from pregnancy are paid at the same level as any other illness in all the plans.  
 ⑤ Per insured maximum

**ALL PLANS**  
**Subject to Deductible and Coinsurance**

Hospital Room and Board.....	Average semi-private rate
Intensive Care Unit.....	Three times average semi-private rate

**Maternity and Routine Nursery Care Benefits**

Benefit Amount.....	As described in the Schedule of Benefits, includes coverage for dependent children
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**“Biologically Based Mental Illness”**      Paid the same as any other illness

Biologically based mental illnesses means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

**Mental/Nervous/Alcoholism and Drug Addiction (other than a “Biologically Based Mental Illness”)**

Lifetime maximum.....	\$ 5,000 - Basic Plan \$ 10,000 - Standard and PPO Plans
Calendar year maximum	
Inpatient.....	\$ 2,000
Outpatient.....	\$ 550
Eligible Charge.....	\$ 50 per visit

**Organ Transplant**

Lifetime maximum.....	\$100,000
Covered transplants.....	Heart, Heart/Lung, Lung, Liver, Kidney, Bone Marrow, Pancreas and Cornea. No other organ transplants are covered.
Covered charges.....	Initial testing and diagnosis; immunosuppressant drug therapy, before and after surgery; complications resulting from surgery, organ rejection/failure; and repeat transplants of same organ.

**Outpatient Physical Therapy**

Eligible charge.....	\$40 per visit
Maximum visits per year.....	20

**Outpatient Prescription Drugs**

Calendar year maximum..... \$ 2,500

**Nursing Home, Convalescent Home, Extended Care Facility, Home Health Care and Hospice**

Calendar year maximum..... \$ 5,000

**Preventative Care**

**Child Wellness Benefit**

Calendar year maximum

Birth to age one..... \$ 500 Includes a maximum benefit amount of \$75.00 for hearing screening.

Ages one through eight..... \$ 150

Mammogram..... 130% of the Medicare reimbursement rate in this state for screening mammography. "Medicare Reimbursement" means the reimbursement rate paid in this state under the Medicare program for screening mammography that does not include digitization or computer aided-detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

Age 35-39..... One mammogram

Age 40-49..... One mammogram every two years or annually if woman has risk factors for breast cancer

Age 50-64..... One mammogram per year

Pap Smear..... Covered

**Skeletal Adjustment/Adjunctive Therapy/Vertebral Manipulation/Dislocation-Subluxation Services**

Eligible charge..... \$25 per visit

Maximum visits per year..... 10

**Assistant Surgeon**

In the event an assisting surgeon is medically necessary to assist in the performance of an operation, the maximum benefit shall not exceed 20% of all eligible charges made by the surgeon performing the operation.

**Durable Medical Equipment**

Purchase or rental (whichever costs less) of durable medical equipment for temporary use, not to exceed a six-month period.

### Multiple Procedures

If two or more procedures are performed in the same operative session, the maximum payment shall be limited to:

- a. if two or more procedures are performed through the same incision, payment shall be limited to the amount payable for the procedure having the greater payment.
- b. if two or more procedures are performed through separate incisions, payments shall be limited to the amount payable for the procedure having the greater payment plus one-half of the amount that would have otherwise been payable for the procedure having the lesser benefit.

### Pregnancy Complications

Complications of pregnancy is a condition that is distinct from the pregnancy, but is adversely affected by pregnancy. Examples of such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, and conditions of comparable severity. It also includes conditions such as emergency non-elective cesarean section, ectopic pregnancy, hyperemesis gravidarum, and spontaneous abortion occurring when a viable birth is not possible.

It does NOT include: false labor, occasional spotting, physician-prescribed rest during pregnancy, morning sickness, pre-eclampsia, or other conditions related to a difficult pregnancy.

### Reconstructive Surgery Following Mastectomies

Coverage will be provided in a manner determined in consultation with the attending physician and the patient for any covered person who is receiving benefits in connection with a mastectomy, who elect breast reconstruction for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage is subject to any applicable deductibles, co-payments, plan maximums and coinsurance.

## GENERAL EXCLUSIONS

No benefits will be paid for:

1. Transportation, except local to or from a Hospital by professional ground ambulance services.
2. Normal childbirth, normal pregnancy or routine nursery care (except as provided in the Schedule of Benefits), elective cesarean section or voluntarily induced abortion.
3. Fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for any treatment related to or connected in any way with the restoration or enhancement of

fertility or the inability to conceive or conception by artificial means, including, but not limited to, in-vitro fertilization or embryo transfer.

4. Replacement of artificial limbs and artificial eyes.
5. Blood or blood plasma which has been replaced.
6. Donation of any body organ by an insured person.
7. Services performed by a person who ordinarily resides in the insured person's home or is a close relative of the insured person or by the insured person's employer or partner.
8. Cosmetic surgery, except as stated in the plan or required to restore a part of the body that has been altered as a result of an accidental bodily injury or illness.
9. Custodial care.
10. Services or treatments not prescribed by a doctor or for services or treatments not shown as covered.
11. An illness arising out of, or in the course of, employment for wages or profit.
12. Expenses incurred after the insurance terminates.
13. Experimental or investigational treatments or services.
14. Eye surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including, but not limited to radial keratotomy; or for eye refractions, eye glasses or contact lens including fitting or examinations.
15. Treatment, services or supplies furnished by a department or agency of the United States Government. This exclusion will not apply to a non-service connected illness of a veteran of the United States armed forces who does not have a service-connected illness.
16. Services and supplies eligible for payment by a government or charitable program, except as required by law.
17. Hearing aids, including fitting and examinations.
18. Non-medically necessary care or treatment of an illness.
19. Which would not be made if no insurance existed.
20. Recreational or educational therapy or vocational rehabilitation.
21. Speech or occupational therapy and related diagnostic testing if the therapy or testing is in connection with or related in any way to the treatment of a learning disability, speech impediment, or developmental delay even though therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma, except as allowed under covered charges.
22. For which the insured is not legally obliged to pay.
23. Treatment or services which are not generally accepted medical practices in the United States for a given illness.

24. Treatment of obesity, morbid obesity or for weight reduction purposes.
25. Illnesses that results from participation in any assault, unlawful act, strike, civil disorder or riot.
26. The treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and the implantation of a penile prosthesis.
27. Routine physical or premarital examination except as may be covered under the child wellness benefit. Mammograms and pap smears are covered
28. A private room in excess of the average semi-private room and board rate.
29. A pre-existing condition. This exclusion relates to conditions treated during the six months immediately preceding the effective date of this coverage. Benefits will be paid for such charges incurred after the end of the period of twelve (12) consecutive months while insured under the policy. This exclusion does not apply to federally eligible individuals.
30. Amounts in excess of reasonable and customary charges.
31. Services or supplies prohibited by law.
32. Sex changes.
33. Sterilization and reversal of sterilization.
34. Charges resulting from any suicide, attempted suicide or intentionally self-inflicted injury or sickness while sane or insane unless such act is the result of an underlying medical condition.
35. Examination, treatment or surgery of the teeth, gums or direct supporting structure, except for repair of injury to sound natural teeth, (including their replacement) as a result of an accidental bodily injury. Treatment must be given within ninety (90) days of the date of the accident to be covered.
36. Illness caused by any act of war, whether or not declared.
37. Surrogate pregnancy.
38. Surgery of the jaw or for any treatment of temporomandibular joint (TMJ) disorder. Treatment of jaw fractures and removal of tumors of the jaw will not be subject to this exclusion.
39. Treatment of complications arising from or connected in any way with a surgical or medical treatment or procedure that is not a covered expense under the terms of the policy, whether or not the insured person was insured under the policy at the time the non-covered treatment or procedure was performed.
40. Foot care due to:
  - a. treatment of weak, strained or flat feet or instability or imbalance of the foot.
  - b. treatment of corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illnesses of similar medical seriousness.
41. For contraceptives, infertility drugs and growth hormones.

**OHIO HEALTH INSURING CORPORATION OHC PLANS**  
**Full Service Closed Panel Summary**

<u>Basic</u>	<u>Standard</u>	<u>BENEFIT</u>
✓	✓	<b>A. Basic Health Care Services</b>
✓	✓	•Inpatient hospital services
✓	✓	•Outpatient medical services
✓	✓	•Basic Physician services
✓	✓	•Diagnostic laboratory services and diagnostic and therapeutic radiological services
✓	✓	•Emergency health services
✓	✓	•Urgent care services
✓	✓	•Preventative services including, but not limited to well child care, periodic physical examinations, cytological exams and screening mammography, voluntary family planning services, infertility services and prenatal obstetrical care
✓	✓	•Biologically based mental illness
	✓	<b>B. Other Covered Services</b>
	✓	•Limited inpatient and outpatient mental health and substance abuse services, other than for biologically based mental illness
	✓	•Skilled nursing care, hospice care, or home health care when medically necessary and in lieu of hospitalization
	✓	•Limited prescription drug coverage
✓	✓	•Reconstructive surgery following mastectomies
✓	✓	<b>C. Cost Sharing Features</b>
\$1,000	\$ 750	•Annual Individual Deductible
\$2,000	\$1,500	•Annual Family Deductible
✓	✓	•Primary Care Physician (“PCP”) office visits \$25.00 co-payment
✓	✓	•Specialist office visit \$40.00 co-payment
40%	30%	•Member Coinsurance Percentage
✓	✓	•Annual out-of pocket maximum

Single.....\$ 5,000.00

Family.....\$10,000.00

## BENEFITS OUTLINE

### BENEFITS

### MEMBER PAYS

#### A. *BASIC HEALTH CARE SERVICES*

Inpatient Hospitalization

Room and Board and related charges including attending and consulting physician

Annual deductible and coinsurance percentage

Emergency Room Services

(prudent lay person standard)

\$110.00 per visit

Urgent Care Services

\$45.00 per visit

Emergency Ambulance Service

(prudent lay person standard)

\$110.00 per use

Outpatient Hospital and Outpatient Surgical Services

Annual deductible and coinsurance percentage

Primary Care Physician Services

Office visits; includes all preventative health services, immunizations and allergy injections.

\$25.00 co-payment per visit

Specialist Physician Services

Office visits and care in other settings

\$40.00 co-payment per visit

Diagnostic Laboratory Services and Diagnostic And Therapeutic Radiological Services

Annual deductible and coinsurance percentage

Maternity Care

Prenatal and postnatal care; hospital physician and other services covered at levels set forth above

Maternity same as any other illness.

**Biologically Based Mental Illness**

Biologically based mental illnesses means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

**BENEFITS**

**MEMBER PAYS**

***B. OTHER COVERED SERVICES***

Inpatient Mental Health and/or  
Substance Abuse Services for other than  
Biologically based mental illness

Annual deductible and  
coinsurance percentage  
Limit of five (5) days per  
member per contract year.

Outpatient Mental Health and/or  
Substance Abuse Services for other than  
Biologically based mental illness

Annual deductible and  
coinsurance percentage  
Benefit limit of \$550.00 per  
member per contract year.

Skilled Nursing Care, Hospice Care  
and Home Health Care

Covered if medically necessary  
and in lieu of hospitalization  
Annual deductible and  
coinsurance percentage

Reconstructive Surgery Following  
Mastectomies  
Covered in manner determined in  
consultation with the attending physician  
and patient.

Hospital, physician and  
other services covered at  
levels set above, same as  
any other illness.

Coverage is included for any covered person who is receiving benefits in connection with a mastectomy, who elects breast reconstruction for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complication at all stages of the mastectomy, including lymphedemas.

## BENEFIT LIMITATIONS

1. Major solid organ transplants (heart, heart-lung, lung, liver and pancreas) must be received through the Ohio Transplant Consortium. The member must also receive pre-certification by the HIC Medical Director. Other covered transplants - bowel, kidney, cornea and bone marrow - are not involved with the Transplant Consortium and will be covered if meeting all pre-certification criteria of the HIC.
2. A HIC participating provider must be used for services unless the required specialty is not under contract with the HIC and use of the non-participating provider is pre-certified by the HIC.
3. All services must be provided by or pre-certified by the member's PCP.
4. Purchase or rental (whichever costs less) of durable medical equipment for temporary use, not to exceed a six-month period.
5. Co-payments on any single covered basic health care service must not exceed 40% of the average cost to the HIC of providing the service.

## OUT-OF-POCKET ANNUAL MAXIMUM

Once a single subscriber has paid \$5,000 out-of-pocket in a contract year, the HIC pays 100% of expenses for covered services. For a family contract, the annual limit is \$10,000 before coverage begins at 100%. Calculation of the member's out-of-pocket maximum does not include the individual and family deductibles, co-payments and coinsurance for inpatient or outpatient mental health or substance abuse services, for other than biologically based mental illness, prescription drugs, hospice care, home health care, skilled nursing care, or the voluntary and unauthorized use of a non-participating physician or facility.

## EXCLUSIONS

No benefits will be paid for:

1. Dental, dental related services or dental related services applied to temporomandibular joint (TMJ) disorder.
2. Cosmetic surgery except reconstructive surgery following mastectomies; breast augmentation and reduction surgery and all related supplies unless medically necessary; penile implants and related services.
3. The treatment of obesity, including diet substitutes and supplements.
4. Experimental or investigational procedures, supplies and drugs.

5. Services that are not medically necessary, except for required preventative services.
6. Examinations specifically for the purpose of obtaining employment, insurance or an examination precedent to engaging in recreational activities, unless obtained in the context of a periodic exam.
7. Recreational, sexual or education therapy. Speech therapy, physical therapy, and occupational therapy are covered on an inpatient basis only.
8. Foot care due to:
  - a. treatment of weak, strained or flat feet or instability or imbalance of the foot.
  - b. treatment of corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illnesses of similar medical seriousness.
9. Vision care benefits, or orthoptics, vision training, low vision aids, or any related type of service, including eyeglasses and contact lenses.
10. Services rendered prior to your effective date of coverage or after your coverage terminates.
11. Services received from a member of your immediate family or rendered by a physician or another provider to himself or herself.
12. Services that are for any illness or injury occurring in the course of employment if whole or partial compensation is available under Worker's Compensation laws or laws of any governmental entity.
13. Any service for which the member has no legal obligation to pay in the absence of this or similar coverage.
14. Services and expenses related to all aspects of organ or tissue procurement rendered or incurred prior to the site of presentation to the donee, including all donor expenses.
15. Transportation and living expenses, except for emergency ambulance services and organ transplants performed outside of the service area.
16. Services received while incarcerated or in the custody of law enforcement officials when such is the financial responsibility of the applicable prison system.
17. Services of non-participating providers, except in an emergency or for out-of-area benefits, or with prior written authorization by the HIC.
18. Services and treatment of mental retardation and other mental health services, except as otherwise set forth in this policy.
19. Hearing aids and related services and supplies, except medical services required for diagnosis and treatment of diseases of, or injury to, the ears.
20. Reconstructive surgery, except as required by other provisions of this contract or deemed medically necessary by a participating physician with the prior approval of the HIC to restore normal physiological functioning.
21. Outpatient private duty nursing or private rooms, unless medically necessary during inpatient hospitalization.

22. Nonprescription drugs, infertility drugs, growth hormones, medications and contraceptive devices, birth control pills, including, but not limited to, Norplant and similar products.
23. Personal comfort items (such as radio, television, telephone and guest meals).
24. Custodial or domiciliary care, convalescent care, skilled nursing care, hospice care or home health care; unless medically necessary and with prior approval by the HIC in lieu of hospitalization or as otherwise required by other provisions of this contract.
25. Physical therapy and rehabilitation services.
26. Reversals of voluntary induced infertility, experimental infertility procedures and non-medically necessary procedures, including but not limited to artificial insemination, in-vitro fertilization ("IVF"), gamete intrafallopian transfer ("GIFT") and zygote intrafallopian transfer ("ZIFT").
27. Procedures, services, and supplies related to sex transformations.
28. Services on which a claim is based from care which is received in a veteran, marine or other federal hospital.
29. Nonmedical ancillary services and long-term rehabilitative services for the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility.
30. Orthotic and prosthetic devices, except as otherwise provided in this policy.
31. Autologous bone marrow transplants, subject to Medicare guidelines.
32. Services of chiropractors, podiatrists, and optometrists.
33. Blood or blood plasma.
34. Kidney dialysis and end stage renal disease treatment after Medicare assumes responsibility.
35. Elective abortions.
36. Experimental artificial organs and related procedures.
37. Elective pre-surgery testing on an inpatient basis without the pre-certification of the HIC Medical Director.
38. Megavitamin therapy, psychosurgery and nutritional based therapy.
39. Salabrasion, chemosurgery, or other such skin abrasion procedures which are performed to remove scars, tattoos, or treat acne.
40. Services performed after the HIC or participating physician has advised the member that further services are not medically appropriate or not covered.

**\$15 CO-PAY GENERIC PRESCRIPTION DRUG BENEFIT**  
**Annual Limit - \$1,000 Individual; \$2,500 Family**

A member in the Standard plan is entitled to the prescription drug benefits on an outpatient basis as listed below; brand name drugs are covered only when no generic equivalent is available.

- a. To receive benefits, all prescription medications must be obtained at a HIC participating pharmacy, as listed in the Provider Directory.
- b. To be eligible for coverage, the medication must bear the federal legend: "CAUTION: Federal law prohibits dispensing without a prescription."
- c. The member pays a \$15.00 co-payment to the pharmacy at the time the initial prescription or refill is received. For prescriptions costing more than \$75.00, the member will pay a 20% copayment to the pharmacy.
- d. A maximum 30-day supply for each prescription or refill is covered. The HIC will cover certain "maintenance drugs" (such as thyroid products and nitroglycerin) up to a 90-day supply or 100-unit doses, whichever is greater, for a single co-payment.
- e. Brand name drugs are not covered if a generic equivalent exists.