

OHIO HEALTH INSURING CORPORATION OHC PLANS
Full Service Closed Panel
Affordable Care Act Compliant
Grandfathered Health Plan Summary

<u>Basic</u>	<u>Standard</u>	<u>BENEFIT</u>
✓	✓	A. Basic Health Care Services
✓	✓	• Inpatient hospital services
✓	✓	• Outpatient medical services
✓	✓	• Basic physician services
✓	✓	• Diagnostic laboratory services and diagnostic and therapeutic radiological services
✓	✓	• Emergency health services
✓	✓	• Urgent care services
✓	✓	• Preventive health care services
✓	✓	• Biologically based mental illness services
✓	✓	• Other basic health care services, including family planning, infertility services, and prenatal obstetrical care
	✓	B. Supplemental Health Care Services
	✓	• Limited inpatient and outpatient mental health and substance abuse services <ul style="list-style-type: none"> ○ Annual Benefit Limit of \$550 per member, per contract year
	✓	• Skilled nursing care, hospice care, or home health care when medically necessary
	✓	• Limited prescription drug coverage: <ul style="list-style-type: none"> ○ Annual Benefit Limits: <ul style="list-style-type: none"> ▪ Individual - \$1,000 ▪ Family - \$2,500
✓	✓	• Reconstructive surgery following mastectomy
✓	✓	C. Cost Sharing Features
✓	✓	• Annual Deductibles: <ul style="list-style-type: none"> ○ Individual ○ Family Deductible
\$1,000	\$750	
\$2,000	\$1,500	

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✓	✓	<ul style="list-style-type: none"> • Basic Health Care Service Copayments: Copayments on any single covered basic health care service must not exceed 40% of the average cost to the HIC of providing the service. <ul style="list-style-type: none"> ○ Primary Care Physician (PCP) Office Visit - \$25 ○ Specialist Office Visit - \$40 ○ Emergency Room Visit - \$110 ○ Urgent Care Visit - \$45 ○ Emergency Ambulance - \$110
	✓	<ul style="list-style-type: none"> • Supplemental Health Care Service Copayments <ul style="list-style-type: none"> ○ Prescription Drugs - \$15 or 20% for eligible brand name drugs costing over \$75
40%	30%	<ul style="list-style-type: none"> • Member Coinsurance Percentage
✓	✓	<ul style="list-style-type: none"> • Annual Out Of Pocket Maximums <ul style="list-style-type: none"> ○ Individual - \$5,000 ○ Family - \$10,000

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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

For an emergency medical condition (prudent layperson standard) treated in any hospital emergency department without prior authorization.

\$110 per visit

Urgent Care Services

\$45 per visit

Emergency Ambulance Services

For an emergency medical condition (prudent layperson standard) without prior authorization.

\$110 per use

Outpatient Hospital and Outpatient Surgical Services

Annual deductible and coinsurance percentage

Primary Care Physician (PCP) Services

Office visits, including all preventive health services, immunizations, and allergy injections

\$25 copayment per visit

Specialist Physician Services

Office visits and care in other settings.

\$40 copayment 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 the same as any other illness.

Same deductibles, coinsurance, and copayments as set forth above for any other illness.

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BENEFITS

Biologically Based Mental Illness

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.

MEMBER PAYS

Same deductibles, coinsurance, and copayments as set forth above for any other illness.

B. SUPPLEMENTAL HEALTH CARE SERVICES

Inpatient Mental Health and/or Substance Abuse Services for other than Biologically Based Mental Illness

Limit of five (5) days per member per contract year.

Annual deductible and coinsurance percentage.

Outpatient Mental Health and/or Substance Abuse Services for other than Biologically Based Mental Illness

Limit of \$550 per member, per contract year

Annual deductible and coinsurance percentage

Skilled Nursing Care, Hospice Care and Home Health Care
Covered if medically necessary.

Annual deductible and coinsurance percentage

Prescription Drug Coverage

Limited to \$1,000 per Individual/\$2,500 per Family, per contract year.

\$15 copayment or 20% for eligible brand name drugs costing over \$75

Coverage for drugs obtained from a participating retail or mail order (if available) pharmacy up to a maximum 30-day supply for each prescription or refill, except for certain “maintenance drugs” (such as thyroid products and nitroglycerin) that are covered for up to a 90-day supply for a single copayment.

Brand name drugs are not covered if a generic equivalent exists.

To be eligible for coverage, the medication must bear the legend: “CAUTION: Federal law prohibits dispensing without a prescription.”

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BENEFITS

Reconstructive Surgery Following Mastectomy

Covered the same as any other illness, in manner determined in consultation with the attending physician and patient.

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.

MEMBER PAYS

Same deductibles, coinsurance, and copayments as set forth above for any other illness.

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 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; or
 - services are for an emergency medical condition (prudent layperson standard) treated in any hospital emergency department (no prior authorization required).
3. All services must be provided by or pre-certified by the member's Primary Care Physician (PCP), except:
 - treatment in any hospital emergency room for an emergency medical condition (prudent layperson standard) or emergency ambulance services; and
4. Coverage of durable medical equipment is limited to purchase or rental for up to a six-month period (whichever costs less).
5. Supplemental benefits for Mental Health and/or Substance Abuse Services (for other than biologically based mental illness are limited to:
 - Inpatient – five (5) days per member, per contract year
 - Outpatient – \$550 per member, per contract year

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6. Supplemental benefits for Skilled Nursing Care, Hospice Care and Home Health Care are covered only if medically necessary.
7. Supplemental benefits for Prescription Drugs are limited to \$1,000 per member/\$2,500 per family, per contract year.

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 health care 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 (except for biologically based mental illness), prescription drugs, hospice care, home health care, skilled nursing care, or the voluntary and unauthorized use of a non-participating specialist or facility (except as set forth for emergency room services).

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EXCLUSIONS

No benefits will be paid for:

1. All dental, dental related services or dental related services applied to TMJ.
2. Except as stated in the benefits outline, cosmetic surgery, breast augmentation and reduction surgery and all related supplies, unless medically necessary; penile implants and related services.
3. Treatment of obesity, including diet substitutes and supplements.
4. Experimental or investigational procedures, supplies and drugs.
5. All services which are not medically necessary.
6. Examinations specifically for the purpose of obtaining employment or insurance or examination precedent to engaging in recreational activities unless obtained in the context of periodic exam.
7. Recreational, sexual or education therapy. Speech therapy, physical therapy, and occupational therapy are covered on an inpatient basis only.
8. For 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 (unless stated otherwise regarding termination of coverage).
11. Services received from a member of the 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.

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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 when authorized in advance in writing by the HIC.
18. Services and treatment of mental retardation and other mental health services, except as otherwise provided.
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. Except as stated in the benefits outline, reconstructive surgery, unless 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 for 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); private rooms, unless medically necessary during inpatient hospitalization.
24. Except as stated in the benefits outline; custodial or domiciliary care, or 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.
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 claim is based from care which is received in a veteran, marine or other federal hospital.

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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. Except as stated in the benefits outline, orthotic and prosthetic devices.
31. Autologous bone marrow transplants, in some instances.
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 to remove scars, tattoos, or which are performed as treatment for acne.
40. Subject to a member's rights to appeal, services performed after the HIC or participating physician has advised the member that further services are not medically appropriate or not covered.