

OHIO INDIVIDUAL INDEMNITY OHC PLANS

Affordable Care Act Compliant Non-Grandfathered Health Plan Summary

Schedule of Benefits

| <u>BENEFIT</u> | <u>BASIC</u> | <u>STANDARD</u> | <u>PPO IN-NETWORK</u> | <u>PPO OUT-OF- NETWORK</u> |
|---|--|--|--|--|
| Calendar Year Individual Deductible ^① | \$1,000 | \$750 | \$750 | \$750 |
| Family Limit on Deductible | NONE | NONE | NONE | NONE |
| Coinsurance ^① | 50/50 | 70/30 | 80/20 | 60/40 |
| Emergency Room Deductible ^② Coinsurance | \$75 50/50 | \$75 70/30 | \$75 80/20 | \$75 80/20 |
| Prescription Drugs | \$15 or 20% for eligible brand name drugs costing over \$75 | \$15 or 20% for eligible brand name drugs costing over \$75 | \$15 or 20% for eligible brand name drugs costing over \$75 | \$15 or 20% for eligible brand name drugs costing over \$75 |
| Individual Calendar Year Out of Pocket Maximum ^③ | \$5,000 | \$5,000 | \$3,000 ^③ | \$5,000 ^④ |
| Family Calendar Year Out of Pocket Maximum | NONE | NONE | NONE | NONE |
| Maternity and Routine Nursery Care Benefits ^⑤ | NONE | \$3,000 | \$3,000 | \$3,000 |
| Calendar Year Maximum Benefits Per Insured: | | | | |
| • For a plan year beginning on or after September 23, 2010, but before September 23, 2011 | \$750,000 | \$1,000,000 | \$1,000,000 | \$1,000,000 |
| • For a plan year beginning on or after September 23, 2011, but before September 23, 2012 | \$1,250,000 | \$1,250,000 | \$1,250,000 | \$1,250,000 |
| • For a plan year beginning on or after September 23, 2012, but before January 1, 2014 | \$2,000,000 | \$2,000,000 | \$2,000,000 | \$2,000,000 |
| • For a plan year beginning on or after January 1, 2014 | NO DOLLAR LIMIT | NO DOLLAR LIMIT | NO DOLLAR LIMIT | NO DOLLAR LIMIT |

- ① Covered Preventive Health Care Services are provided without a copayment, coinsurance, or deductible, except when an out of network provider is used to provide these services under the PPO plan.
- ② Emergency Room Deductible is waived if admitted to the hospital. This deductible is in addition to the Calendar Year Deductible.
- ③ This maximum is in addition to the Calendar Year Deductible.
- ④ In addition to the Calendar Year Deductible, (except for eligible Emergency Room charges that will be considered on a no more restrictive basis than In-Network services). In Network coinsurance and out of pocket amounts do not apply toward the out of pocket maximum for Out Of Network charges.
- ⑤ Standard and PPO plan maternity and routine nursery care benefits for a normal delivery are limited to \$3,000 per occurrence. Complications in all plans are paid same as any other illness.

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Covered Service and Benefit Limitations

ALL PLANS

Benefits for covered services are subject to applicable plan deductibles, coinsurance and calendar year benefit maximums as described in the Schedule of Benefits.

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| <p>Hospital Room and Board:</p> <ul style="list-style-type: none"> • Intensive Care Unit | <p>Average semi-private rate. Three times average semi-private rate.</p> |
| <p>Emergency Room Services: For an emergency medical condition (prudent layperson standard) treated in any hospital emergency department without prior authorization.</p> | <p>Under the PPO Plan, Out-Of-Network eligible charges will be considered on a no more restrictive basis than In-Network charges.</p> |
| <p>Maternity and Routine Nursery Care Benefits:</p> <ul style="list-style-type: none"> • Includes coverage for dependent children • <u>Basic plan</u> • <u>Standard and PPO plans</u> • <u>Complications of Pregnancy</u> Complications of pregnancy is a condition that is distinct from 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. Complications of pregnancy does NOT include: false labor, occasional spotting, physician-prescribed rest during pregnancy, morning sickness, pre-eclampsia, or other conditions related to a difficult pregnancy. | <p>Limited to complications of pregnancy.</p> <p>Maternity and routine nursery care benefits for a normal delivery limited to \$3,000 per occurrence.</p> <p>Covered the same as any other illness.</p> |
| <p>Mental/Nervous/Alcoholism and Drug Addiction: Inpatient and Outpatient services (limited to eligible charge), except for Biologically Based Mental Illness.</p> | <p>Outpatient eligible charge limited to \$50 per visit.</p> |
| <p>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.</p> | <p>Covered the same as any other illness.</p> |

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| Organ Transplant: | |
| 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 |
| Nursing Home, Convalescent Home, Extended Care Facility, Home Health Care and Hospice: | |
| Covered only if medically necessary. | |
| Preventive Health Care: | |
| Required preventive health care services that depending on age, may include, but not be limited to: | Except when an out of network, provider is used to provide these services under the PPO plan, eligible services are covered without any copayment, coinsurance, or deductible, |
| <ul style="list-style-type: none"> • Screening Mammography (includes one initial screening between age 35 and 40) • Annual screening for cervical cancer • Child Health Supervision • Screenings and tests for diseases • Mental Health screenings, including substance abuse • Healthy lifestyle counseling • Vaccines and immunizations • Pregnancy counseling and screenings • Well baby and well child visits through age 21 • Periodic physical exams | |
| Skeletal Adjustment/Adjunctive Therapy/Vertebral Manipulation/Dislocation-Subluxation Services: | |
| Eligible charge | \$25 per visit |
| Durable Medical Equipment: | |
| Purchase or rental for up to six months (whichever costs less) of durable medical equipment. | |
| Surgery: | |
| <ul style="list-style-type: none"> • Assistant Surgeon - Medically necessary assistance in performance of an operation | Maximum benefit shall not exceed 20% of all eligible charges made by the surgeon performing the operation. |
| <ul style="list-style-type: none"> • Two or more procedures performed in the same operative session | Maximum payment shall be limited to: <ul style="list-style-type: none"> a. if two or more procedures are performed through the same incision, payment shall be limited the amount payable for the procedure having the greater payment. b. payment 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. |

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| <p>Reconstructive Surgery Following Mastectomy: 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 elects breast reconstruction for:</p> <ul style="list-style-type: none"> • reconstruction of the breast on which the mastectomy has been performed; • surgery and reconstruction of the other breast to produce a symmetrical appearance; and <ul style="list-style-type: none"> • prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. | <p>Covered the same as any other illness.</p> |
| <p>Prescription Drugs 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.</p> <p>Brand name drugs are not covered if a generic equivalent exists.</p> <p>To be eligible for coverage, the medication must bear the legend: “CAUTION: Federal law prohibits dispensing without a prescription.”</p> | <p>\$15 copayment or 20% for eligible brand name drugs costing over \$75</p> |

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GENERAL EXCLUSIONS

Except for required Preventive Health Care Services, no benefits will be paid for charges:

1. For transportation, except local, to or from a Hospital, by professional ground ambulance services.
2. For normal childbirth, normal pregnancy or routine nursery care (except as provided in the Schedule of Benefits), elective cesarean section or voluntarily induced abortion.
3. For 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. For replacement of artificial limbs and artificial eyes.
5. For blood or blood plasma which has been replaced.
6. For donation of any body organ by an insured person.
7. For 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. Except as stated in the plan, for any cosmetic surgery, unless required to restore a part of the body that has been altered as a result of an accidental bodily injury or illness.
9. For custodial care.
10. Applied to a deductible or coinsurance amount under any benefit of the policy.
11. For services or treatment not prescribed by a doctor or for services or treatment not shown as covered.
12. Due to an illness arising out of, or in the course of, employment for wages or profit.
13. For expenses incurred after the insurance terminates.
14. For treatment or services experimental or investigational in nature.
15. For 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 any examinations.
16. For 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.
17. For services and supplies eligible for payment by a government or charitable program, except as required by law.
18. For hearing aids, including fitting and examinations.
19. Which are not necessary to the care or treatment of an illness.
20. Which would not be made if no insurance existed.

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21. For recreational or educational therapy or vocational rehabilitation.
22. Except as allowed under covered charges subject to limitations, for 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.
23. For which the insured person is not legally obliged to pay.
24. For treatment or services which are not generally accepted medical practices in the United States for a given illness.
25. For treatment of obesity, morbid obesity or for weight reduction purposes.
26. For illness that results from participation in any assault, unlawful act, strike, civil disorder or riot.
27. For the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and the implantation of a penile prosthesis.
28. For routine physical or premarital examination except as may be covered under the child wellness benefit. Mammograms and pap smears are covered.
29. For a private room in excess of the average semi-private room and board rate.
30. Except for an enrollee younger than age 19 or a federally eligible individual, no benefits will be paid for charges due to a pre-existing condition. This limitation relates only to conditions treated during the six months immediately preceding the effective date of 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.
31. In excess of reasonable and customary charges.
32. For services or supplies prohibited by law.
33. For sex changes.
34. For sterilization and reversal of sterilization.
35. 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.
36. For 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.
37. For an illness caused by any act of war, whether or not declared.
38. For surrogate pregnancy.
39. For 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.

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40. For the 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.
41. 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.
42. For contraceptives, infertility drugs and growth hormones.