



STATE OF OHIO

SCHEDULE OF BENEFITS

Primary care physician (“PCP”), Ob/gyn physician, specialty physician (including secondary care physician (“SCP”), certain diabetic services, and emergency room and urgent care visits require a copay.

To determine the maximum amount of expenses you or your family can incur in one year, refer to the annual out-of-pocket maximum listed below. Expenses you incur for copays, not to include supplemental services (i.e., prescription copays) count toward satisfying the out-of-pocket maximum.

	Individual	Family
Annual Out-of-Pocket Maximum	\$1,000	\$2,000

The copay amount contributed by any one family member shall not exceed that of an individual annual out-of-pocket maximum amount.

The annual out-of-pocket maximum refers to the amount of money you pay out of your pocket for eligible health care expenses. Copays, both fixed dollar amounts and percentages, which you pay for covered services, count toward your out-of-pocket maximum. There is an annual individual out-of-pocket maximum and an annual family out-of-pocket maximum. To meet the annual family out-of-pocket maximum, you can count the annual eligible expenses incurred by two or more family members.

SERVICES REQUIRING PREAUTHORIZATION

- Magnetic Resonance Imaging (MRI)
- Positron Emission Tomography (PET)
- Magnetic Resonance Angiography (MRA)

If you, or your physician, have a question regarding Preauthorization, please contact a Plan Customer Service Representative at (740) 695-7902, (888) 847-7902, TDD: (740) 695-7919 or (800) 622-3925.

NOTE: TRUE EMERGENCY OR URGENT CARE SERVICES ARE COVERED WITHOUT REGARD TO PREAUTHORIZATION.

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<p>INPATIENT HOSPITAL SERVICES</p>	
<p>•Hospitalization: semi-private room, ICU/CCU, nursing care, maternity and birthing room (48 hrs. normal, 96 hrs. cesarean), nursery, operating room, therapy (oxygen and respiratory, physical, occupational and speech), laboratory, therapeutic and diagnostic x-ray, observation bed, other services and supplies</p>	<p>20% coinsurance/admission</p>
<p>•Physician visits and services</p>	<p>20% coinsurance/admission</p>
<p>•Rehabilitation</p>	<p>20% coinsurance/admission</p>
<p>•Skilled Nursing Facility: there may be instances where a non-contracting facility may be covered, for additional information call (740) 695-7902 or (888) 847-7902</p>	<p>20% coinsurance/days 1-180, days 181+ 40% coinsurance/admission</p>
<p>PHYSICIAN OFFICE VISITS</p>	
<p>•Audiology: audiological exam, one per contract year</p>	<p>\$15 copay/visit</p>
<p>•Chiropractic care: limited services, subject to Plan review, limited to a maximum of 20 visits per contract year</p>	<p>\$15 copay/visit</p>
<p>•Maternity care: pre and post-natal care/obstetrical services*</p> <p>*Post delivery follow-up visits: 48 hrs. normal, 96 hrs. cesarean, if mother and physician determine that the hospital stay is to be shortened, 72 hrs. of follow-up care will be provided at no charge and deductible waived</p>	<p>\$15 copay initial visit only</p>
<p>•Ob/gyn care</p>	<p>\$15 copay/visit</p>
<p>•Podiatry care</p>	<p>\$15 copay/visit</p>
<p>•Primary care physician (“PCP”)</p>	<p>\$15 copay/visit</p>

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<p>•Specialist care</p>	<p>\$15 copay/visit</p>
<p>DIABETIC COVERAGE (Treatment and/or management for insulin or non-insulin dependent diabetes, diabetes during pregnancy or those known to have risk factors)</p>	
<p>•Annual retinal exam by Optometrist or Ophthalmologist*</p> <p>* If the exam reveals an abnormal condition, future treatment may require Preauthorization and applicable participant costs will apply</p>	<p>\$0</p>
<p>•Insulin pumps and pump supplies: covered under DME benefit, limited to the Plan’s basic allowance</p>	<p>20% coinsurance</p>
<p>•Laboratory*</p> <p>* The Plan and the American Diabetes Association recommend fasting blood glucose, lipid profile at least annually, glycosylated hemoglobin (HbA1c) at least twice per year, microalbuminuria at least annually</p>	<p>20% coinsurance</p>
<p>•Pharmacological agents: 31-day supply dispensed monthly, subject to formulary</p>	<p>Covered under Prescription Benefit</p>
<p>•Self management education services: limited to 16 visits (maximum of eight individual and eight group) per contract year, medically appropriate education on proper self-management, treatment and diet</p>	<p>\$0</p>
<p>•Supplies: glucometers, syringes, lancets, glucose test strips, alcohol swabs, carp-u-jet, urine ketone testing strips and penlets</p>	<p>\$0 upon participation in a disease management program or 20% coinsurance with no participation in a disease management program</p>

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<p>OTHER SERVICES (PHYSICIAN’S OFFICE, HOSPITAL, HOME SETTING, OTHER PLAN OR APPROVED PROVIDER) <i>Note: applicable office visit copay may apply</i></p>	
<p>•Allergy injections</p>	<p>\$15 copay/visit</p>
<p>•Ambulance service: emergency transportation, medically necessary only *</p> <p>*Scheduled transportation will be reviewed for medical necessity and appropriateness</p>	<p>20% coinsurance/incident</p>
<p>•Ambulette service: will be reviewed for medical necessity and appropriateness</p>	<p>20% coinsurance/incident</p>
<p>•Biofeedback therapy: for urinary or fecal incontinence only</p>	<p>20% coinsurance/visit</p>
<p>•Cardiac rehabilitation: limited to a maximum of 12 weeks or 36 visits per heart attack or heart surgery</p>	<p>20% coinsurance/visit</p>
<p>•Durable medical equipment (“DME”) and DME supplies: rental or purchase is the option of the Plan, limited to Plan’s basic allowance</p>	<p>20% coinsurance</p>
<p>•Emergency care: copay waived if admitted</p>	<p>\$75 copay then 20% coinsurance/incident</p>
<p>•Family planning: contraceptive injections (such as Depo Provera), IUD, diaphragm</p>	<p>20% coinsurance/visit/injection</p>
<p>•Hearing aid: limited to Plan’s basic allowance, one per lifetime, approved referral required</p>	<p>20% coinsurance</p>
<p>•Home health: limited to 100 visits or 180 days whichever is greater per contract year, serviced for intermittent skilled care only (home health aide not covered)</p>	<p>20% coinsurance/visit</p>
<p>•Home IV therapy/infusion therapy</p>	<p>20% coinsurance/visit</p>
<p>•Hospice care</p>	<p>\$0</p>

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<p>•Infertility services: limited to basic health care</p>	20% coinsurance/visit/injection
<p>•Laboratory, therapeutic and diagnostic x-ray: to include ultrasound, MRI, MRA, CAT and PET scans</p>	20% coinsurance
<p>•Oral surgical services: accidental or injury only, repair limited to gums only</p>	20% coinsurance
<p>•Orthotics: limited to Plan’s basic allowance</p>	20% coinsurance
<p>•Outpatient surgery: to include office setting</p>	20% coinsurance
<p>•Preventive care: injections, immunizations (pediatric/childhood, adolescent and adult); child health supervision services (review of physical and emotional status birth to age 9), physical exam (one per calendar year) and well child care</p>	\$0
<p>•Prosthetic and prosthetic supplies: limited to Plan’s basic allowance</p>	20% coinsurance
<p>•Pulmonary rehabilitation: limited to a maximum of 12 weeks or 36 visits per contract year</p>	20% coinsurance/visit
<p>•Radiation and chemotherapy</p>	20% coinsurance/visit
<p>•Specialty drugs: high cost medications used to treat very specific diseases that require extensive management for safety and effectiveness.</p>	Covered under Prescription Benefit
<p>•Temporomandibular joint dysfunction (“TMJ”): non-experimental, medically necessary services</p>	20% coinsurance/visit
<p>•Therapy (physical, occupational and speech): <i>short-term only</i>, each limited to the lesser of maintenance level not to exceed 20 visits per occurrence</p>	\$15 copay/visit per therapy type

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<p>•Urgent care: copay waived if admitted</p>	<p>\$25 copay/incident</p>
<p>MENTAL HEALTH/SUBSTANCE ABUSE SERVICES, DENTAL AND VISION SERVICES, LIFE INSURANCE BENEFIT</p>	
<p>•Mental health/substance abuse services for all State employees in HMOs or Ohio Med will be provided by a separate Behavioral Health Vendor under contract with the Ohio Department of Administrative Services. For more information call (800)-852-1091</p>	
<p>•Dental and vision services, life insurance benefit are provided for State employees through either the Ohio Department of Administrative Services or OCSEA Benefits Trust</p>	
<p>OTHER INFORMATION</p>	
<p>If services fall in more than one copay category the higher copay shall be applicable</p>	
<p>When services are limited to a maximum number of days, treatments, visits, etc., each visit, treatment, etc., must be medically necessary and appropriate to be covered.</p>	
<p>Percentage copays are based on the amount paid, allowed or negotiated by the Plan</p>	
<p>Participants are responsible for any financial obligations for non-covered services</p>	

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