

OHIO State Plans	Standard PPO Plan Plan pays for services at <b>PARTICIPATING</b> providers	Standard PPO Plan Plan pays for services at <b>NONPARTICIPATING</b> providers	Basic Indemnity Fee-for-Service Plan	
<b>Preventive Care</b>	<ul style="list-style-type: none"> <li>Well-baby/well-child exam (\$500 per covered person per calendar year birth to age 1; \$150 per covered person per calendar year age 1 through age 8)</li> </ul>	80% after deductible	60% after deductible	50% after deductible
	<ul style="list-style-type: none"> <li>Annual Pap smear</li> </ul>	80% after deductible	60% after deductible	50% after deductible
	<ul style="list-style-type: none"> <li>Mammogram</li> </ul>	80% after deductible (maximum of \$85 per calendar year)	60% after deductible (maximum of \$85 per calendar year)	50% after deductible (maximum of \$85 per calendar year)
<b>Physician Services</b>	<ul style="list-style-type: none"> <li>Office visits (including diagnostic lab and X-rays)</li> <li>Allergy testing, injections and serum</li> <li>Inpatient services</li> </ul>	80% after deductible	60% after deductible	50% after deductible
<b>Hospital Services</b>	<ul style="list-style-type: none"> <li>Inpatient care</li> <li>Outpatient surgery–facility</li> <li>Outpatient nonsurgical</li> </ul>	80% after deductible	60% after deductible	50% after deductible
	<ul style="list-style-type: none"> <li>Emergency room (including physician visits) (emergency room deductible waived if admitted)</li> </ul>	\$75 emergency room deductible per visit then 80% after medical deductible	\$75 emergency room deductible per visit then 60% after medical deductible	\$75 emergency room deductible per visit then 50% after medical deductible
<b>Prescription Drugs</b>	<ul style="list-style-type: none"> <li>\$2,500 maximum per covered person per calendar year</li> </ul>	80% after deductible	60% after deductible	50% after deductible
<b>Other Medical Services</b>	<ul style="list-style-type: none"> <li>Home health care, skilled nursing facility, hospice (2)</li> </ul>	80% after deductible (up to a combined calendar year maximum of \$5,000 for all skilled nursing facility, home health care and hospice)	60% after deductible (up to a combined calendar year maximum of \$5,000 for all skilled nursing facility, home health care and hospice)	50% after deductible (up to a combined calendar year maximum of \$5,000 for all skilled nursing facility, home health care and hospice)
	<ul style="list-style-type: none"> <li>Physical medicine (outpatient physical therapy and services to restore speech or swallowing impairment and cognitive therapy pertaining to head injury or stroke) – 20 visits per year maximum</li> </ul>	80% after deductible limited to \$40 per covered person per visit	60% after deductible limited to \$40 per covered person per visit	50% after deductible limited to \$40 per covered person per visit
	<ul style="list-style-type: none"> <li>Skeletal adjustment, adjunctive therapy, vertebral manipulation and dislocation-subluxation – 10 visits per year maximum</li> </ul>	80% after deductible limited to \$25 per covered person per visit	60% after deductible limited to \$25 per covered person per visit	50% after deductible limited to \$25 per covered person per visit
	<ul style="list-style-type: none"> <li>Ambulance</li> <li>Durable medical equipment (limited to six months) (2)</li> <li>Transplant Services (\$100,000 lifetime maximum per covered person) (2)</li> </ul>	80% after deductible	60% after deductible	50% after deductible
	<ul style="list-style-type: none"> <li>Maternity and routine nursery care</li> </ul>	80% after deductible \$3,000 maximum per pregnancy Complications of pregnancy and sick baby services only paid the same as any other sickness	60% after deductible \$3,000 maximum per pregnancy Complications of pregnancy and sick baby services only paid the same as any other sickness	Complications of pregnancy and sick baby services only paid the same as any other sickness

OHIO State Plans	Standard PPO Plan		Basic Indemnity
	Plan pays for services at <b>PARTICIPATING</b> providers	Plan pays for services at <b>NONPARTICIPATING</b> providers	Fee-for-Service Plan
<b>Mental Health</b> <i>(includes mental disorders, alcohol and chemical dependence)</i>	<ul style="list-style-type: none"> <li>Inpatient services <b>80%</b> after deductible (\$2,000 – calendar year combined maximum per covered person to \$10,000 combined lifetime maximum for all inpatient and outpatient care)</li> <li>Outpatient care and office therapy session <b>80%</b> after deductible limited to \$50 per covered person per visit (\$550 calendar year combined maximum per covered person to \$10,000 combined lifetime maximum for all inpatient and outpatient care)</li> </ul>	<ul style="list-style-type: none"> <li>Inpatient services <b>60%</b> after deductible (\$2,000 – calendar year combined maximum per covered person to \$10,000 combined lifetime maximum for all inpatient and outpatient care)</li> <li>Outpatient care and office therapy session <b>60%</b> after deductible limited to \$50 per covered person per visit (\$550 calendar year combined maximum per covered person to \$10,000 combined lifetime maximum for all inpatient and outpatient care)</li> </ul>	<ul style="list-style-type: none"> <li>Inpatient services <b>50%</b> after deductible (\$2,000 – calendar year combined maximum per covered person to \$5,000 combined lifetime maximum for all inpatient and outpatient care)</li> <li>Outpatient care and office therapy session <b>50%</b> after deductible limited to \$50 per covered person per visit (\$550 calendar year combined maximum per covered person to \$5,000 combined lifetime maximum for all inpatient and outpatient care)</li> </ul>
<b>Maximum Out-of-Pocket Expense</b> <i>(mental health, alcohol and chemical dependence services do not apply)</i>	<ul style="list-style-type: none"> <li>Individual <i>(must be satisfied by each covered person)</i> \$3,000</li> </ul>	\$5,000	\$5,000
<b>Annual Deductible</b>	<ul style="list-style-type: none"> <li>Individual <i>(must be satisfied by each covered person)</i> \$750</li> </ul>	\$750	\$1,000
<b>Calendar Maximum</b> <i>(per covered person)</i>	None (3)	None (3)	\$50,000 combined maximum for all covered expenses
<b>Lifetime Maximum</b> <i>(includes mental health and transplant services which have separate maximum limits)</i>		\$1,000,000 per covered person	None <i>(except for transplants and mental health services as shown above)</i>

**To be covered, services must be medically necessary. Please see your policy for more information on medical necessity and other specific plan benefits.**

- (1) No coverage for children age 9 or older.
- (2) Prior authorization required in order to be eligible for these benefits.
- (3) Except for well-baby/well-child exams, home health care, skilled nursing facility, hospice, mammograms and prescription drugs as shown above.

*This document and accompanying materials contain a general summary of benefits, exclusions and limitations. Please refer to the policy for actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the policy will govern.*

**Payments** - Plan benefits are paid based on the maximum allowable fee, as defined in your policy. Participating providers agree to accept the maximum allowable fee, as listed in negotiated payment schedules, as payment in full.

For services rendered by nonparticipating providers, the member is responsible for charges exceeding the maximum allowable fee as explained in your policy.

**Participating primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgement or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.**



# Limitations and Exclusions

This is an outline of the limitations and exclusions for the Ohio Basic and Standard plans. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions.

Unless stated otherwise, no services will be provided for the following situations.

1. Transportation, except local, to or from a hospital, by professional ground ambulance services;
2. Normal childbirth, normal pregnancy or routine nursery care (basic plan only), elective cesarean section or voluntarily induced abortion;
3. Infertility services;
4. Replacement of artificial limbs and artificial eyes;
5. Blood or blood plasma which has been replaced;
6. Donation of any body organ by a covered person;
7. Services performed by a person who ordinarily resides in the covered person's home or is a close relative of the covered person or by the covered person's employer or partner;
8. Except as stated in the plan, any cosmetic surgery, unless required to restore a part of the body which has been altered as a result of the following events or conditions:
  - a. Accidental bodily injury;
  - b. Surgery; or
  - c. Disease;
9. Custodial care;
10. Charges applied to a deductible or coinsurance amount under any benefit of the plan;
11. Services or treatment not prescribed by a doctor or for services or treatment not listed as a covered expense;
12. Charges that are due to an illness arising out of, or in the course of, employment for wages or profit;
13. Expense incurred before the covered person's effective date under this plan or after the covered person's coverage under this plan terminates;
14. Any service which is experimental, investigational, or for research purposes;
15. 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 any examinations;
16. 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. Services and supplies eligible for payment by a government or charitable program, except as required by law;
18. Hearing aids, including fitting and examinations;
19. Services which are not necessary to the care or treatment of an illness or which are not medically necessary;
20. Charges which would not be made if no insurance existed;
21. Recreational or educational therapy or vocational rehabilitation;
22. Except as described in the plan, 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. Charges which the covered person is not legally obligated to pay;
24. Treatment or services which are not generally accepted medical practices in the United States for a given illness;
25. Treatment of obesity, morbid obesity or for weight reduction purposes;
26. Illness that results from participation in any assault, unlawful act, strike, civil disorder or riot;
27. Treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and the implantation of a penile prosthesis;
28. Routine physical or premarital examination except as covered under the child health supervision services benefit. Mammograms and pap smears are covered;
29. A private room in excess of the average semi-private room and board rate;
30. Pre-existing conditions to the extent specified in the plan;
31. Charges in excess of the maximum allowable fee for the service;
32. Services or supplies prohibited by law;
33. Sex changes;
34. Sterilization and reversal of sterilization;
35. Charges resulting from any suicide, attempted suicide or intentionally self-inflicted bodily injury or sickness while sane or insane, unless such act is the result of an underlying medical condition;
36. Examinations, treatment or surgery of the teeth, gums or direct supporting structure, except for repair of injury to a sound natural tooth, (including replacement) as a result of an accidental bodily injury. Treatment must be given within ninety (90) days of the date of the accident;
37. An illness caused by any act of war, whether or not declared;
38. Surrogate pregnancy;
39. Surgery of the jaw or for any treatment of temporomandibular joint (TMJ) disorder. Treatment of jaw fractures and removal of tumors of the jaw are not subject to this exclusion;
40. 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 plan, whether or not the covered person was insured under the plan at the time the noncovered treatment or procedure was performed
41. Foot care due to:
  - a. Treatment of weak, strained or flat feet or instability or imbalance of the foot;
  - b. Treatment of corns, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illnesses of similar medical seriousness;
42. Contraceptives, infertility drugs and growth hormones.

