

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

Benefits	Covered?	Quantitative Limit?	Limit Quantity	Limit Units	"Other" Limit Units Description	Min Stay	Exclusions	Additional Explanation	Does this benefit have additional limitations or restrictions?
<b>Primary Care Visit to Treat an Injury or Illness, including routine required visits</b>	Covered	No					Non-interactive telemedicine services.		No
<b>Specialist Visit</b>	Covered	No					Non-interactive telemedicine services.		No
<b>Other Practitioner Office Visit</b>	Covered	No					Non-interactive telemedicine services.		No
<b>Outpatient Facility Services</b>	Covered	No					Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.		Yes - also see specific exceptions to these exclusions and/or additional exclusions that are detailed under separately listed benefits or services (e.g., bariatric surgery, cosmetic surgery)
<b>Physician Medical and Surgical Services in an Outpatient Facility</b>	Covered	No					Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.		Yes - also see specific exceptions to these exclusions and/or additional exclusions that are detailed under separately listed benefits or services (e.g., bariatric surgery, cosmetic surgery)
<b>Hospice Services</b>	Covered	No					Services provided by volunteers; housekeeping services.		No
<b>Non-Emergency care When Traveling Outside the U.S.</b>	Not Covered							NOTE: CMS clarified during an EHB Q&A call on 4/15/2013, that this coverage is not considered an Essential Benefit, but a network related issue.	

Ohio Essential Health Benefits Resource Document for 2016 Plan Year

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Dental Services	Not Covered								
Infertility Treatment	Covered*							*Infertility and voluntary family planning services are required benefits under state law for HMO plans <b>only</b> per ORC § 1751.01 (A)(1)(h), and must be provided in accordance with Ohio Bulletin No. 2009-07.	See ORC § 1751.01 (A)(1)(h)
Long-Term/Custodial Nursing Home Care	Not Covered								
Private duty nursing services	Covered	Yes	90 - 110*	Visits per year			Private duty nursing services in an inpatient setting.	Home nursing services provided through home health care. Limit applies to Private duty nursing in home setting, and is in addition to the Home Health Care Services limit.	*Quantitative Limit represents number of visits to meet established actuarial equivalent of benchmark plan annual dollar limits. Annual and lifetime \$ limits will no longer apply.
Routine Eye Exam	Not Covered						Routine eye exam and refraction are not covered, as well as services for vision training and orthoptics, eyeglasses and eyewear.		
Urgent Care Services in an Urgent Care Center or Facility	Covered	No							No

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

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<b>Home Health Care Services</b>	Covered	Yes	100	Visits per year			Food, housing, homemaker services and home delivered meals; home or outpatient hemodialysis services; physician charges; helpful environmental materials; Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider; Services provided by a member of the patient's immediate family; Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities; Manipulation therapy services rendered in the home.	Medical treatment provided in the home on a part time or intermittent basis including visits by a licensed health care professional, including a nurse, therapist, or home health aide; and physical, speech, and occupational therapy. When these therapy services are provided as part of home health they are not subject to separate visit limits for therapy services. 100 visit/year limit not applicable to home infusion therapy or private duty nursing render in home setting.	No
<b>Emergency Room Services</b>	Covered	No					Care received in and emergency room that is not emergency care.		No
<b>Emergency Transportation/ Ambulance</b>	Covered	No					Non covered services for ambulance include but are not limited to, trips to a physician's office or clinic, a morgue or a funeral home.	Ambulance transportation from home, scene of accident or medical emergency to hospital; between hospitals; between hospital and skilled nursing facility; from hospital or skilled nursing facility to patient's home.	No
<b>Inpatient Hospital Services</b>	Covered	No					Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.	Facility billed services while in an inpatient facility. Includes room and board, nursing services, and ancillary services and supplies.	Yes - also see specific exceptions to these exclusions and/or additional exclusions that are detailed under separately listed benefits or services (e.g., bariatric surgery, cosmetic surgery)

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

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<b>Inpatient Physician and Surgical Services</b>	Covered	Yes	1	Other	One (1) Inpatient visit/day per Physician or other Professional Provider		Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.	Facility billed services while in an inpatient facility. Includes room and board, nursing services, and ancillary services and supplies.	Yes - also see specific exceptions to these exclusions and/or additional exclusions that are detailed under separately listed benefits or services (e.g., bariatric surgery, cosmetic surgery)
<b>Bariatric Surgery</b>	Not Covered*						Bariatric surgery, regardless of the purpose it is proposed or performed. This includes Roux- en-Y(RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Anthem plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Certificate. <b>See Additional Explanation column for details of when this exclusion DOES NOT apply.</b>	Directly related means that the treatment or surgery occurred as a direct result of the bariatric surgery and would not have taken place in the absence of the bariatric surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions. <b>*All medically necessary Basic Health Care services must be covered by a HIC. Complications from a non-covered procedure that require the need for any medically necessary Basic Health Care Service must be covered same as any other services.</b>	

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

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Cosmetic Surgery	Not Covered*						For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgeries, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Certificate. See Additional Explanation column for details of when this exclusion DOES NOT apply.	Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery, and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions. <b>*All medically necessary Basic Health Care services must be covered by a HIC. Complications from a non-covered procedure that require the need for any medically necessary Basic Health Care Service must be covered same as any other services.</b>	
Skilled Nursing Facility	Covered	Yes	90	Days per year			Custodial or residential care in a skilled nursing facility or any other facility is not covered except as rendered as part of Hospice care.	Items and services provided as an inpatient in a skilled nursing bed of skilled nursing facility or hospital, including room and board in semi-private accommodations; rehabilitative services; and drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies.	No
Prenatal and Postnatal Care	Covered	No					Services related to surrogacy if member is not the surrogate.	Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered.	No

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

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<b>Delivery and All Inpatient Facility and Professional Services for Maternity Care</b>	Covered	No				48/ 96	Services related to surrogacy if member is not the surrogate.	Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered. 48 hour minimum length of stay for vaginal delivery; 96 hour minimum length of stay for cesarean delivery.	No
<b>Mental/Behavioral Health Outpatient Services</b>	Covered	Yes		Other	Mental Health Parity		Custodial or Domiciliary Care. Room and board charges unless the treatment provided meets Medical Necessity criteria for Inpatient admission for patient's condition. Supervised living or halfway houses, services or care provided or billed by a school, halfway house, custodial care center for the developmentally disabled or outward bound programs, even if psychotherapy is included, unless those centers or facilities are required to be covered under state or federal law; marital and sexual counseling/therapy; and wilderness camps.	Coverage and limits must comply with state mandate and the parity standards set forth in the federal Mental Health Parity and Addiction Equity Act of 2008.	<a href="#">Mental Health Parity and Addiction Equity Act of 2008</a>
<b>Mental/Behavioral Health Inpatient Services</b>	Covered	Yes		Other	Mental Health Parity		Custodial or Domiciliary Care. Room and board charges unless the treatment provided meets Medical Necessity criteria for Inpatient admission for patient's condition. Supervised living or halfway houses, services or care provided or billed by a school, halfway house, custodial care center for the developmentally disabled or outward bound programs, even if psychotherapy is included, unless those centers or facilities are required to be covered under state or federal law; marital and sexual counseling/therapy; and wilderness camps.	Coverage and limits must comply with state mandate and the parity standards set forth in the federal Mental Health Parity and Addiction Equity Act of 2008.	<a href="#">Mental Health Parity and Addiction Equity Act of 2008</a>

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

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<b>Substance Abuse Disorder Outpatient Services</b>	Covered	Yes		Other	Mental Health Parity		Custodial or Domiciliary Care. Room and board charges unless the treatment provided meets Medical Necessity criteria for Inpatient admission for patient's condition. Supervised living or halfway houses, services or care provided or billed by a school, halfway house, custodial care center for the developmentally disabled or outward bound programs, even if psychotherapy is included, unless those centers or facilities are required to be covered under state or federal law; marital and sexual counseling/therapy; and wilderness camps.	Coverage and limits must comply with state mandate and the parity standards set forth in the federal Mental Health Parity and Addiction Equity Act of 2008.	<a href="#">Mental Health Parity and Addiction Equity Act of 2008</a>
<b>Substance Abuse Disorder Inpatient Services</b>	Covered	Yes		Other	Mental Health Parity		Custodial or Domiciliary Care. Room and board charges unless the treatment provided meets Medical Necessity criteria for Inpatient admission for patient's condition. Supervised living or halfway houses, services or care provided or billed by a school, halfway house, custodial care center for the developmentally disabled or outward bound programs, even if psychotherapy is included, unless those centers or facilities are required to be covered under state or federal law; marital and sexual counseling/therapy; and wilderness camps.	Coverage and limits must comply with state mandate and the parity standards set forth in the federal Mental Health Parity and Addiction Equity Act of 2008.	<a href="#">Mental Health Parity and Addiction Equity Act of 2008</a>

Ohio Essential Health Benefits Resource Document for 2016 Plan Year

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Generic Prescription Drugs	Covered	No					Drugs for weight loss; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis. <b>Except where covered under Preventive Care/Screening/Immunization benefits:</b> over the counter drugs and drugs with over the counter equivalents or nutritional and/or dietary supplements.	Must comply with Regulations at 45 C.F.R. 156.122, providing coverage for at least the greater of (1) one drug in every USP category and class, or (2) the same number of prescription drugs in each USP category and class as the state's EHB-benchmark plan; coverage must be provided at no cost sharing for over the counter drugs, stop smoking aids, and nutritional or dietary supplements that are required to be covered under the Preventive/Screening/Immunization benefits.	<a href="#">Prescription Drug EHB-Benchmark Plan Benefits by Category and Class (link pending update for 2016)</a>
Preferred Brand Prescription Drugs	Covered	No					Drugs for weight loss; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis. <b>Except where covered under Preventive Care/Screening/Immunization benefits requirements:</b> over the counter drugs and drugs with over the counter equivalents or nutritional and/or dietary supplements.	Must comply with Regulations at 45 C.F.R. 156.122, providing coverage for at least the greater of (1) one drug in every USP category and class, or (2) the same number of prescription drugs in each USP category and class as the state's EHB-benchmark plan; coverage must be provided at no cost sharing for over the counter drugs, stop smoking aids, and nutritional or dietary supplements that are required to be covered under the Preventive/Screening/Immunization benefits.	<a href="#">Prescription Drug EHB-Benchmark Plan Benefits by Category and Class (link pending update for 2016 Plan Year)</a>

Ohio Essential Health Benefits Resource Document for 2016 Plan Year

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Non-Preferred Brand Prescription Drugs	Covered	No					Drugs for weight loss; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis. <b>Except where covered under Preventive Care/Screening/Immunization benefits requirements:</b> over the counter drugs and drugs with over the counter equivalents or nutritional and/or dietary supplements.	Must comply with Regulations at 45 C.F.R. 156.122, providing coverage for at least the greater of (1) one drug in every USP category and class, or (2) the same number of prescription drugs in each USP category and class as the state's EHB-benchmark plan; coverage must be provided at no cost sharing for over the counter drugs, stop smoking aids, and nutritional or dietary supplements that are required to be covered under the Preventive/Screening/Immunization benefits.	<a href="#">Prescription Drug EHB-Benchmark Plan Benefits by Category and Class (link pending update for 2016 Plan Year)</a>
Specialty Prescription Drugs	Covered	No					Drugs for weight loss; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis. <b>Except where covered under Preventive Care/Screening/Immunization benefits requirements:</b> over the counter drugs and drugs with over the counter equivalents or nutritional and/or dietary supplements.	Must comply with Regulations at 45 C.F.R. 156.122, providing coverage for at least the greater of (1) one drug in every USP category and class, or (2) the same number of prescription drugs in each USP category and class as the state's EHB-benchmark plan; coverage must be provided at no cost sharing for over the counter drugs, stop smoking aids, and nutritional or dietary supplements that are required to be covered under the Preventive/Screening/Immunization benefits.	<a href="#">Prescription Drug EHB-Benchmark Plan Benefits by Category and Class (link pending update for 2016 Plan Year)</a>

Ohio Essential Health Benefits Resource Document for 2016 Plan Year

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Outpatient Rehabilitation Services	Covered	Yes	116	Other	Combined total visits/year for all therapies.*		<p><b>Physical Therapy</b> - Non Covered Services include: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.</p> <p><b>Occupational Therapy</b> - Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non Covered Services include: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.</p> <p><b>Cardiac Rehab</b> - Home programs, on-going conditioning and maintenance are not covered.</p> <p><b>Pulmonary Rehab</b> - Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.</p> <p><b>General Exclusions</b> - Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.</p>	*Includes physical therapy, occupational therapy, speech therapy, pulmonary therapy and cardiac rehabilitation. Separate 20 visit limits for PT, OT, ST, Pulmonary Rehab; 36 visit limit for Cardiac Rehab.	

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

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<b>Habilitation Services</b>	Covered							Issuers must: 1) define habilitation coverage as health care services and devices that help a person keep, learn or improve skills and functioning for daily living and 2) include coverage required through the Governor's letter dated December 26, 2012.	<a href="#">Ohio Governor's letter dated 12/26/2012</a>  <a href="#">ACA Final Rule - Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation</a>
<b>Osteopathic/Chiropractic Manipulation Therapy</b>	Covered	Yes	12	Visits per year			Manipulation therapy services rendered in the home as part of Home Care Services are not covered.	Benefit limit applies for Osteopathic/Chiropractic Manipulation Therapy.	No

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

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<b>Medical Equipment and Supplies</b>	Covered	No					<p><b>Non covered services include:</b> Items for personal hygiene, environmental control or convenience; Exercise equipment;</p> <p><b>Repairs and replacement</b> - Repair and replacement due to misuse, malicious breakage or gross neglect. Replacement of lost or stolen items.</p> <p><b>Medical and Surgical Supplies</b> - Adhesive tape, band aids, cotton tipped applicators; Arch supports; Doughnut cushions; Hot packs, ice bags; vitamins; medinjectors;</p> <p><b>Durable Medical Equipment</b> - Air conditioners; Ice bags/ coldpack pump; Raised toilet seats; Rental of equipment if the Member is in a Facility that is expected to provide such equipment; Translift chairs; Treadmill exerciser; Tub chair used in shower.</p> <p><b>Prosthetics</b> - Dentures, replacing teeth or structures directly supporting teeth; Dental appliances; Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets; Artificial heart implants; Wigs (except following cancer treatment); Penile prosthesis in men suffering impotency resulting from disease or injury;</p> <p><b>Orthotics</b> - Orthopedic shoes (except therapeutic shoes for diabetics); Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace; Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies); Garter belts or similar devices.</p>	<p>Covered services include: Durable medical equipment, medical devices and supplies, prosthetics and appliances, including cochlear implants.</p> <p>Limit of four (4) surgical bras following mastectomy per benefit period; LVAD covered only as bridge to heart transplant.</p>	No
<b>Hearing Aids</b>	Not Covered								See Durable Medical Equipment benefits re: coverage for cochlear implants.
<b>Diagnostic Tests</b>	Covered	No							No
<b>Advanced Diagnostic Imaging Services</b>	Covered	No							No

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

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<b>Preventive Care/Screenings and Immunizations</b>	Covered	No						Coverage must include all preventive services described in section 2713 of the PHS Act, as added by section 1001 of the ACA.	No
<b>Routine Foot Care</b>	Not Covered						Routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including: cleaning and soaking the feet; applying skin creams in order to maintain skin tone; other services that are performed when there is not a localized illness, injury or symptom involving the foot; cosmetic foot care.		
<b>Acupuncture</b>	Not Covered						Services or supplies related to alternative or complementary medicine. Examples of services in this category include: acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergiel synchronization technique (BEST), iridology- study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.		
<b>Weight Loss Programs</b>	Not Covered						Weight loss programs, whether or not they are pursued under medical or physician supervision.		
<b>Routine eye exam</b>	Covered	Yes	1	Visits per year				Required coverage will include benefits specified in the FEDVIP FEP Blue Vision - High Option plan, including low vision benefits.	<a href="#">FEP BlueVision - High Option2012 Plan Benefit Brochure</a>

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

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Eyeglasses for children	Covered	Yes	1	Other	1 pair of glasses (lenses and frames per year)			Required coverage will include benefits specified in the FEDVIP FEP Blue Vision - High Option plan, including low vision benefits.	<a href="#">FEP BlueVision - High Option2012 Plan Benefit Brochure</a>
Dental Exams	Covered	Yes	1	Other	1 every 6 months			Required coverage will include benefits specified in the FEDVIP MetLife Federal Dental - High Option Plan., which includes basic, intermediate and major dental services and supplies as well as medically-necessary orthodontia.	<a href="#">MetLife Federal Dental Plan - High Option 2012 Plan Benefit Brochure</a>
Radiation Therapy	Covered	No							No
Chemotherapy	Covered	No						Must provide no less favorable treatment or cost sharing for orally administered cancer medications than is provided for intravenously administered or injected cancer medication or comply with a \$100/prescription fill "safe harbor" option. Please see ORC §1751.69 or ORC §3923.85 for more information.	No
Infusion Therapy	Covered	No							No
Renal Dialysis/ Hemodialysis	Covered	No							No
Allergy Treatment, including testing and serum.	Covered	No							No
Injectable drugs and other drugs administered in a provider's office or other outpatient setting	Covered	No							No

Ohio Essential Health Benefits Resource Document for 2016 Plan Year

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Biofeedback	Not Covered								
Vision Correction After Surgery or Accident	Covered	No					Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. <b>See further information regarding exceptions to this exclusion in the Additional Explanation column.</b>	Prescription glasses or contact lenses when required as a result of surgery or for the treatment of accidental injury. <b>Coverage includes contact lenses or glasses after intraocular lens implantation for treatment of cataract or aphakia and the first pair of contact lenses or glasses to replace the function of the human lens for conditions caused by cataract surgery or injury. A donor lens is not the first lens.</b>	No
Medical supplies, equipment, and education for diabetes care for all diabetics	Covered	No						Medical supplies, equipment, and education for diabetes care for all diabetics, including Orthopedic/therapeutic shoes.	No

Ohio Essential Health Benefits Resource Document for 2016 Plan Year

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Accidental Dental	Covered	Yes	3000*	Other	Dollars per Occurrence*		Damage to teeth due to chewing or biting is not deemed an accidental injury and is not covered.	Dental services resulting from an accidental injury when treatment is performed within 12 months after the injury. The benefit limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than the Physician performing the service, or to services that we are required by law to cover. Coverage includes oral examinations, x-rays, tests and laboratory examinations, restorations, prosthetic services, oral surgery, mandibular/maxillary reconstruction, anesthesia. Other covered dental services include facility charges for Outpatient services for the removal of teeth or for other dental processes if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.	*Quantitative Limit represents established actuarial equivalent of benchmark plan annual dollar limits. Annual and lifetime \$ limits will no longer apply.

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

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<b>Human Organ and Tissue Transplant Services</b>	Covered	No						Medically necessary human organ and tissue transplant services. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan. Additional covered services include unrelated donor searches, live donor services, and transportation and lodging. Issuers must define Transplant Benefit Period and provide levels of coverage and benefits during the Transplant Benefit Period as specifically provided in the Ohio Benchmark Plan contract document.	Yes
<b>Human Organ and Tissue Transplant Services - Transportation and Lodging</b>	Covered	Yes	10000	dollars	per transplant		Non covered transportation and lodging includes child care; mileage within the transplant city; rental cars, buses, taxis or shuttle service, except as specifically approved; frequent flyer miles; coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the transplant; telephone calls; laundry; postage; entertainment; interim visits to a medical facility while waiting for the actual transplant procedure; travel expenses for donor companion/ caregiver; return visits for the donor for a treatment of a condition found during evaluation.	The Plan will provide assistance with reasonable and necessary travel expenses when patient is required to travel more than 75 miles from residence to reach the facility where the Covered Transplant Procedure will be performed. Assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.	Yes
<b>Human Organ and Tissue Transplant Services - Unrelated donor search</b>	Covered	Yes	30000	dollars	per transplant				Yes

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

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<b>Inpatient Rehabilitation Facilities Including Room &amp; Board Charges, Physician Fees, Imaging, Testing, and Supplies</b>	Covered	Yes	60	Days per year			Admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.	Includes coverage for Day Rehabilitation Program services subject to combined 60 day limit with inpatient services.	Yes
<b>Rehab Facilities Including Room &amp; Board Charges, Physician Fees, Imaging, Testing, and Supplies</b>	Covered	Yes	60	Days per year			Admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.		Yes
<b>Basic Dental Care – Child</b>	Covered	No						Required coverage will include benefits specified in the FEDVIP MetLife Federal Dental - High Option Plan., which includes basic, intermediate and major dental services and supplies as well as medically-necessary orthodontia.	<a href="#">MetLife Federal Dental Plan - High Option 2012 Plan Benefit Brochure</a>
<b>Major Dental Care – Child</b>	Covered	No						Required coverage will include benefits specified in the FEDVIP MetLife Federal Dental - High Option Plan., which includes basic, intermediate and major dental services and supplies as well as medically-necessary orthodontia.	<a href="#">MetLife Federal Dental Plan - High Option 2012 Plan Benefit Brochure</a>
<b>Medically necessary Orthodontia - Child</b>	Covered	No						Required coverage will include benefits specified in the FEDVIP MetLife Federal Dental - High Option Plan., which includes basic, intermediate and major dental services and supplies as well as medically-necessary orthodontia.	<a href="#">MetLife Federal Dental Plan - High Option 2012 Plan Benefit Brochure</a>

Ohio Essential Health Benefits Resource Document for 2016 Plan Year

Benefits	Covered?	Quantitative Limit?	Limit Quantity	Limit Units	"Other" Limit Units Description	Min Stay	Exclusions	Additional Explanation	Does this benefit have additional limitations or restrictions?
Temporomandibular or Craniomandibular Joint/Jaw Treatment	Covered	No							No
Sterilization	Covered	No						Female sterilization must be provided as a Preventive service in accordance with ACA. Male sterilization is not a required Preventive service but is an Ohio EHB. Male sterilization is not eligible for religious exemption.	No
Reconstructive Services	Covered	No					Reconstructive services (unless required by law).	Benefits include Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child; Breast reconstruction resulting from a mastectomy; Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger; Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia; Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect; Tongue release for diagnosis of tongue-tied; Congenial disorders that cause skull deformity such as Crouzon's disease; Cleft lip; Cleft palate.	No
Off Label Prescription Drugs	Covered	No						Coverage must comply with ORC §§ 3923.60, 3923.61, and 1751.66, as well as Regulations at 45 C.F.R. 156.122.	No

**Ohio Essential Health Benefits Resource Document for 2016 Plan Year**

Benefits	Covered?	Quantitative Limit?	Limit Quantity	Limit Units	"Other" Limit Units Description	Min Stay	Exclusions	Additional Explanation	Does this benefit have additional limitations or restrictions?
<b>Specified Non-Routine Dental Services</b>	Covered	No						1) Limited to facility charges for Outpatient Services for the removal of teeth or for other dental processes only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient; 2) Dental xrays, supplies, & appliances and all associated expenses, including hospitalization and anesthesia are limited to services/treatments for: transplant preparation; initiation of immunosuppressives; or direct treatment of acute traumatic injury, cancer, or cleft palate.	No
<b>Nutritional Counseling</b>	Covered	No							No