Ohio Essential Health Benefit Resource Document

OH EHB #	Benefit	EHB	Is the Benefit Covered?	Quantitative Limit on Service?	Limit Quantity	Limit Unit	Exclusions	Explanations
1	**Primary Care Visit to Treat an Injury or Illness**	Yes	Covered	No			Telephone consultations or consultations via electronic mail or internet/web site, except as required by law or as otherwise provided in plan document.	
2	**Specialist Visit**	Yes	Covered	No			Telephone consultations or consultations via electronic mail or internet/web site, except as required by law or as otherwise provided in plan document.	
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Yes	Covered	No			Telephone consultations or consultations via electronic mail or internet/web site, except as required by law or as otherwise provided in plan document.	
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Yes	Covered	No			Surgical treatment of dental conditions, 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; cosmetic surgery; bariatric surgery.	See specific exceptions to these exclusions and/or additional exclusions that are detailed in plan document; benefits for facility charges for Outpatient Services are payable 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
5	**Outpatient Surgery Physician/Surgical Services**	Yes	Covered	No			Surgical treatment of dental conditions, 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; cosmetic surgery; bariatric surgery.	See specific exceptions to these exclusions and/or additional exclusions that are detailed in plan document.
6	**Hospice Services**	Yes	Covered	No			Services provided by volunteers and housekeeping services.	To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician.
7	**Routine Dental Services (Adult)**	No	Not Covered	No				
8	**Infertility Treatment**	No	Covered	No			Infertility treatment is excluded except as required under state law for HMO plans.	Infertility and voluntary family planning services are required benefits under state law for HMO plans only per ORC § 1751.01 (A)(1)(h), and must be provided in accordance with Ohio Department of Insurance Bulletin No. 2009-07.
9	**Long-Term/Custodial Nursing Home Care**	No	Not Covered	No				
10	**Private-Duty Nursing**	Yes	Covered	Yes	90-110	Visit(s) per Benefit Period	Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility.	Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit; Quantitative Limit has been determined as 90 - 110 visits per year and represents the number of visits to meet the established actuarial equivalent of benchmark plan annual dollar limits. Annual and lifetime dollar limits will no longer apply.

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11	**Routine Eye Exam (Adult)**	No	Not Covered	No				Routine eye exam and refraction are not covered, as well as services for vision training and orthoptics, eyeglasses and eyewear (except for eyeglasses or contact lenses for cataract surgery or injury covered under durable medical benefits).
12	**Urgent Care Centers or Facilities**	Yes	Covered	No				
13	**Home Health Care Services**	Yes	Covered	Yes	100	Visit(s) per Benefit Period	Food, housing, homemaker services and home delivered meals; Home or Outpatient hemodialysis services (these are covered under Therapy Services); Physician charges; Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices); 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.	When therapy services are provided in the home (including physical, speech, and occupational therapy) as part of home health care services, they are not subject to separate visit limits for therapy services. The 100 visit/year limit is also not applicable to home infusion therapy or private duty nursing rendered in the home setting.
14	**Emergency Room Services**	Yes	Covered	No			For care received in an emergency room, which is not, Emergency Care, including, but not limited to suture removal in an emergency room.	
15	**Emergency Transportation/Ambulance**	Yes	Covered	No			Non Covered Services for Ambulance include but are not limited to, trips to: a Physician's office or clinic; a morgue or funeral home; ambulance usage when another type of transportation can be used without endangering the member's health or any ambulance usage for the convenience of the member, family, or physician; transport by ambulette.	Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals: from home, scene of accident or medical emergency to a hospital; between hospitals; between a hospital and skilled nursing facility; or from a hospital or skilled nursing facility to home; ambulance trips must be made to the closest facility that can give covered services appropriate for the member's condition.
16	**Inpatient Hospital Services (e.g., Hospital Stay)**	Yes	Covered	No			Surgical treatment of dental conditions, 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; cosmetic surgery; bariatric surgery.	There are specific exceptions to certain exclusions and/or additional exclusions that are detailed in plan document; inpatient hospital services include charges from a hospital, skilled nursing facility or other provider for room, board, general nursing services; and ancillary (related) services. Limited to a combined 60 days per Benefit Period maximum for both Inpatient and outpatient day rehabilitation therapy services.

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17	**Inpatient Physician and Surgical Services**	Yes	Covered	No			Surgical treatment of dental conditions, 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; cosmetic surgery; bariatric surgery.	There are specific exceptions to certain exclusions and/or additional exclusions that are detailed in plan document; inpatient medical care visits limited to one visit per day by any one physician.
18	**Bariatric Surgery**	No	Not Covered	No			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, are not covered. See 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, 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 during the procedure or in the immediate post-operative time frame. All medically necessary Basic Health Care services must be covered by an HMO plan. 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.
19	**Cosmetic Surgery**	No	Not Covered	No			For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of skin or to change the size, shape or appearance of facial or body features (such as nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgeries are not covered. See 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, and would not have taken place in the absence of, the cosmetic surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions during the procedure or in the immediate post-operative time frame. All medically necessary Basic Health Care services must be covered by an HMO plan. 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.
20	**Skilled Nursing Facility**	Yes	Covered	Yes	90	Day(s) per Benefit Period	Custodial or domiciliary care.	Benefits include 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.

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21	**Prenatal and Postnatal Care**	Yes	Covered	No			Any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).	Includes post-delivery follow-up care performed, by a physician or nurse, within 72 hours of discharge, through home health care visits or, at patient's discretion, in a medical setting. This coverage includes, but is not limited to parent education; assistance and training in breast or bottle feeding; and routine maternal or neonatal tests and screening (including collection of sample for hereditary and metabolic newborn screening).
22	**Delivery and All Inpatient Services for Maternity Care**	Yes	Covered	No			Any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple). Unless otherwise required under state or federal law, if Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.	Coverage for the Inpatient postpartum stay for mother and newborn child in a hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care.
23	**Mental/Behavioral Health Outpatient Services**	Yes	Covered	No			Custodial or domiciliary Care. Supervised living or halfway houses, services or care provided or billed by a hotel, health resort, convalescent/rest/nursing home, infirmary, or school/special education environment, 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 mandates and the parity standards set forth in the federal Mental Health Parity and Addiction Equity Act of 2008.
24	**Mental/Behavioral Health Inpatient Services**	Yes	Covered	No			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 hotel, health resort, convalescent/rest/nursing home, infirmary, or school/special education environment, 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 mandates and the parity standards set forth in the federal Mental Health Parity and Addiction Equity Act of 2008.
25	**Substance Abuse Disorder Outpatient Services**	Yes	Covered	No			Services or care provided or billed by a halfway house, hotel, health resort, infirmary, or school/special education environment, 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 mandates and the parity standards set forth in the federal Mental Health Parity and Addiction Equity Act of 2008.
26	**Substance Abuse Disorder Inpatient Services**	Yes	Covered	No			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 hotel, health resort, convalescent/rest/nursing home, infirmary, or school/special education environment, 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 mandates and the parity standards set forth in the federal Mental Health Parity and Addiction Equity Act of 2008.

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27	**Generic Drugs**	Yes	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 onychomycosis; over the counter drugs and drugs with over the counter equivalents or nutritional and/or dietary supplements, except where covered under Preventive Care/Screening/Immunization benefits; drugs not approved by the FDA or not requiring a prescription by federal law (except injectable insulin); refills of lost or stolen medications.	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.
28	**Preferred Brand Drugs**	Yes	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 onychomycosis; over the counter drugs and drugs with over the counter equivalents or nutritional and/or dietary supplements, except where covered under Preventive Care/Screening/Immunization benefits; drugs not approved by the FDA or not requiring a prescription by federal law (except injectable insulin); refills of lost or stolen medications.	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.
29	**Non-Preferred Brand Drugs**	Yes	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 onychomycosis; over the counter drugs and drugs with over the counter equivalents or nutritional and/or dietary supplements, except where covered under Preventive Care/Screening/Immunization benefits; drugs not approved by the FDA or not requiring a prescription by federal law (except injectable insulin); refills of lost or stolen medications.	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.
30	**Specialty Drugs**	Yes	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 onychomycosis; over the counter drugs and drugs with over the counter equivalents or nutritional and/or dietary supplements, except where covered under Preventive Care/Screening/Immunization benefits; drugs not approved by the FDA or not requiring a prescription by federal law (except injectable insulin); refills of lost or stolen medications.	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.

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31	**Outpatient Rehabilitation Services**	Yes	Covered	Yes	116	Visit(s) per Benefit Period	Non-Covered Services include: Physical Therapy - maintenance therapy, repetitive exercise, range of motion and passive exercises that are not related to restoration of a specific loss of function; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening. Occupational Therapy - diversional, recreational, vocational therapies and supplies; 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; adaptions to the home. Cardiac Rehabilitation – home programs, ongoing conditioning and maintenance. Pulmonary Rehabilitation – services provided in the acute inpatient rehabilitation setting	Therapy Services rendered in the home as part of Home Care Services will be subject to the Home Care Services visit limits; outpatient rehabilitation services visit limits will not apply. If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable maximum visits per Benefit Period listed below: Physical, Occupational and Speech Therapy limited to 20 visits each. Cardiac Rehabilitation limited to 36 visits. Pulmonary Rehabilitation limited to 20 visits, except if rendered as part of Physical Therapy, the Physical Therapy visit limit will apply. Benefit also includes Physical Medicine and Day Rehabilitation Therapy services on an Outpatient basis. Limited to a combined 60 days per Benefit Period maximum for both Inpatient and outpatient day rehabilitation therapy services.
32	**Habilitation Services**	Yes	Covered	No				Limits may apply to some services; includes benefits for health care services and devices that help a person keep, learn or improve skills and functioning for daily living, including treatment of Autism Spectrum Disorders to children (0 - 21), which at a minimum shall include: (1) Out-Patient Physical Rehabilitation Services including (a) Speech and Language therapy and/or Occupational therapy, 20 visits per year of each service; and (b) Clinical Therapeutic Intervention, which include but are not limited to Applied Behavioral Analysis, 20 hours per week; and (2) Mental/Behavioral Health Outpatient Services to provide consultation, assessment, development and oversight of treatment plans.
33	**Chiropractic Care**	Yes	Covered	Yes	12	Visit(s) per Benefit Period	Manipulation therapy services rendered in the home as part of Home Care Services.	Benefit limit applies for Osteopathic/Chiropractic Manipulation Therapy.

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34	**Durable Medical Equipment**	Yes	Covered	No			Items for personal hygiene, environmental control or convenience; exercise equipment; repair and replacement due to misuse, malicious breakage or gross neglect, loss or theft; medical and surgical supplies (usually stocked in the home for general use like- band aids, thermometers, and petroleum jelly); arch supports; doughnut cushions; vitamins; medi-jectors; air conditioners; hot packs; ice bags/ cold pack pump; raised toilet seats; rental of equipment where facility is expected to provide such equipment; trans lift chairs; treadmill exerciser; tub chair; dentures, dental appliances; non-rigid appliances; artificial heart implants; wigs (except following cancer treatment); penile prosthesis in men suffering impotency; orthopedic shoes (except therapeutic shoes for diabetics); foot support devices and corrective shoes, unless they are an integral part of a leg brace; standard elastic stockings and other supplies not specially made and fitted (except as specified under medical supplies); garter belts or similar devices.	Covered services include durable medical equipment, medical devices and supplies, prosthetics and appliances, including cochlear implants and eyeglasses/contact lenses for cataract surgery or injury, and medical/surgical supplies and equipment that serve only a medical purpose for the management of disease. Benefit limits: Wigs are limited to the first one following cancer treatment not to exceed one per Benefit Period; limit of four (4) surgical bras following mastectomy per benefit period; (as required by the Women's Health and Cancer Rights Act); Left Ventricular Artificial Devices (LVAD) covered only as bridge to heart transplant.
35	**Hearing Aids**	No	Not Covered	No				Cochlear implants are covered as durable medical equipment.
36	**Imaging (CT/PET Scans, MRIs)**	Yes	Covered	No				
37	**Preventive Care/Screening/Immunization**	Yes	Covered	No				Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF); Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration including: women's contraceptives, sterilization procedures, and counseling; breastfeeding support, supplies, and counseling (benefits for breast pumps are limited to one pump per benefit period); and gestational diabetes screening; routine screening mammograms; routine cytologic screening; child health supervision services from birth to age 9.
38	**Routine Foot Care**	No	Not Covered	No				
39	**Acupuncture**	No	Not Covered	No				
40	**Weight Loss Programs**	No	Not Covered	No				
41	**Routine Eye Exam for Children**	Yes	Covered	Yes	1	Exam(s) per Year		Coverage includes benefits specified in the FEDVIP FEP Blue Vision - High Option plan, including low vision benefits.
42	**Eye Glasses for Children**	Yes	Covered	Yes	1	Item(s) per Year		Coverage includes benefits specified in the FEDVIP FEP Blue Vision - High Option plan, including low vision benefits.
43	**Dental Check-Up for Children**	Yes	Covered	Yes	1	Exam(s) per 6 Months		Coverage includes benefits specified in the FEDVIP MetLife Federal Dental - High Option Plan.

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44	**Rehabilitative Speech Therapy**	Yes	Covered	Yes	20	Visit(s) per Benefit Period		
45	**Rehabilitative Occupational and Rehabilitative Physical Therapy**	Yes	Covered	Yes	40	Visit(s) per Benefit Period	Non-Covered Services include: Physical Therapy - maintenance therapy, repetitive exercise, range of motion and passive exercises that are not related to restoration of a specific loss of function; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening. Occupational Therapy - diversional, recreational, vocational therapies and supplies; 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; adaptions to the home.	Occupational Therapy is limited to 20 visits per benefit period, and Physical Therapy is limited to a separate 20 visits per benefit period.
46	**Well Baby Visits and Care**	Yes	Covered	No				
47	**Laboratory Outpatient and Professional Services**	Yes	Covered	No				
48	**X-rays and Diagnostic Imaging**	Yes	Covered	No				
49	**Basic Dental Care - Child**	Yes	Covered	No				Coverage includes benefits specified in the FEDVIP MetLife Federal Dental - High Option Plan.
50	**Orthodontia - Child**	Yes	Covered	No				Coverage includes benefits specified in the FEDVIP MetLife Federal Dental - High Option Plan.
51	**Major Dental Care - Child**	Yes	Covered	No				Coverage includes benefits specified in the FEDVIP MetLife Federal Dental - High Option Plan.
52	**Basic Dental Care - Adult**	No	Not Covered	No			Adult dental treatment, regardless of origin or cause, is excluded except as specified in the base-benchmark plan when related to accidental injury (limits apply), or for certain services related to transplant preparation, initiation of immunosuppresives, or direct treatment of acute traumatic injury, cancer or cleft palate. Excluded dental treatment includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums.	See Accidental Dental benefit for additional information.
53	**Orthodontia - Adult**	No	Not Covered	No			Adult dental treatment, regardless of origin or cause, is excluded except as specified in the base-benchmark plan when related to accidental injury (limits apply), or for certain services related to transplant preparation, initiation of immunosuppresives, or direct treatment of acute traumatic injury, cancer or cleft palate. Excluded dental treatment includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums.	See Accidental Dental benefit for additional information.

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54	**Major Dental Care – Adult**	No	Not Covered	No			Adult dental treatment, regardless of origin or cause, is excluded except as specified in the base-benchmark plan when related to accidental injury (limits apply), or for certain services related to transplant preparation, initiation of immunosuppresives, or direct treatment of acute traumatic injury, cancer or cleft palate. Excluded dental treatment includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums.	See Accidental Dental benefit for additional information.
55	**Abortion for Which Public Funding is Prohibited**	No	Not Covered	No				Coverage for nontherapeutic abortion is prohibited for Qualified Health Plans per Ohio Revised Code § 3901.87.
56	**Transplant**	Yes	Covered	No				Includes coverage for unrelated donor search services ($30,000 per transplant/) and travel/lodging as approved by the plan ($10,000 per transplant/). Transplant services benefits apply to any medically necessary human organ and stem cell / bone marrow transplants and transfusions including necessary acquisition procedures, harvest and storage, necessary preparatory myeloablative therapy, and initial evaluation/testing to determine eligibility as a transplant candidate.
57	**Accidental Dental**	Yes	Covered	Yes	3000	Dollar(s) per Episode	Damage to teeth due to chewing or biting is not deemed an accidental injury and is not covered.	Quantitative Limit represents established actuarial equivalent of benchmark plan annual dollar limits. Annual and lifetime dollar limits will no longer apply. Coverage for 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 covered services required by law; coverage includes oral examinations, x-rays, tests and laboratory examinations, restorations, prosthetic services, oral surgery, mandibular/maxillary reconstruction, anesthesia and 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.
58	**Dialysis**	Yes	Covered	No				Benefits include supportive use of an artificial kidney machine.
59	**Allergy Testing**	Yes	Covered	No				
60	**Chemotherapy**	Yes	Covered	No				
61	**Radiation**	Yes	Covered	No				
62	**Diabetes Education**	Yes	Covered	No				Diabetes Self-Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition.

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63	**Prosthetic Devices**	Yes	Covered	No			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.	Benefits for artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that 1) Replace all or part of a missing body part and its adjoining tissues; or 2) Replace all or part of the function of a permanently useless or malfunctioning body part.
64	**Infusion Therapy**	Yes	Covered	No				Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy
65	**Treatment for Temporomandibular Joint Disorders**	Yes	Covered	No				Benefits provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.
66	**Nutritional Counseling**	Yes	Covered	No				Covered benefit under home health services and covered as USPSTF A or B recommendation under preventive health services (includes diet counseling for adults at higher risk for chronic disease, obesity screening and counseling for all adults, and healthy diet counseling for adults with cardiovascular risk factors).
67	**Reconstructive Surgery**	Yes	Covered	No			Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a covered service under the plan; coverage for reconstructive services does not apply to orthognathic surgery.	Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy.