OhioHealthy

OhioHealthy Level-Funded Solutions

Consumer-Directed Health Plan Designs

The Right Fit for Small Groups

When it comes to finding the right option for your level-funded health benefits plan, OhioHealthy has you covered. We can help you find the right design to meet your needs.

Plan Name	Unity CDHP 6000-110	Unity CDHP 3500-112	Unity CDHP 5000-113	Unity CDHP 3000-117	Unity CDHP 3000-121
Benefit Period	Calendar Year	Calendar Year	Calendar Year	Calendar Year	Calendar Year
Plan Code	OHLF-110	OHLF-112	OHLF-113	OHLF-117	OHLF-121
Product Type	CDHP	CDHP	CDHP	CDHP	CDHP
Individual Deductible (In Network/Out of Network)	$6,000/$15,000	$3,500/$7,500	$5,000/$10,000	$3,000/$7,500	$3,000/$7,500
Coinsurance (In Network/Out of Network Percent)	100/70	90/60	90/60	90/60	100/70
Individual Out-Of-Pocket Limit (In Network/Out of Network)	$6,000/$17,500	$7,000/$20,000	$7,000/$20,000	$4,000/$15000	$3000/$10000
Deductible Type	Embedded	Non-Embedded (Aggregate)	Embedded	Non-Embedded (Aggregate)	Embedded
Family Multiplier	2	2	2	2	2
Physician	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Specialist	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
X-ray/Lab	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Maternity and Routine Nursery Care	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Urgent Care	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Outpatient Advanced Imaging	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
ER Visit	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Therapies	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Alternative Medicine	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Prescription Drug Card	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Inpatient Admission/Surgery Access Fees	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Teladoc	ded + coins	ded + coins	ded + coins	ded + coins	ded + coins
Domestic Partner Coverage	Yes	Yes	Yes	Yes	Yes

These are summaries of proposed benefits and are a general description of plan highlights only. All benefits are subject to the plan conditions and limitations of the plan document. Limitation, exclusions and renewability apply and are described in the plan document. Coverage is not effective without written notification from OhioHealthy Health Insuring Corporation or OhioHealthy Insurance Company. Insurance products are underwritten by OhioHealthy Health Insuring Corporation and OhioHealthy Insurance Company. Plans are administered by OhioHealthy Health Insuring Corporation and OhioHealthy Insurance Company. Stop Loss Insurance provided by Trustmark Life Insurance Company.

Plan Definitions

• BENEFIT PERIOD

Calendar Year – The 12-month period from January 1 to December 31 during which covered expenses can be applied to satisfy the deductible. The accumulation period resets every January 1.

• OUT-OF-POCKET LIMITS[1]

The individual out-of-pocket limit is the amount of covered charges the member must pay each year before benefits will be paid at 100 percent. The family out-of-pocket limit is two times the individual out-of-pocket limit. When family coverage is selected, an individual's in-network out-of-pocket limit cannot exceed the 2023 cost-sharing limit of $9,100, depending on the effective date of the plan year.

Note: For members with family coverage, benefits are paid at 100 percent once the entire family out-of-pocket limit is met. The out-of-pocket limit includes the plan deductible and coinsurance.

• DEDUCTIBLE TYPE

Aggregate: Benefits are payable once the entire family deductible is met. When family coverage is selected, an individual's in-network out-of-pocket limit cannot exceed the 2023 cost-sharing limit of $9,100, depending on the effective date of the plan year.

Embedded: Benefits are payable for a member once either the individual deductible is met, or for the entire family once the family deductible is met. In order for the self-funded plan design to be qualified for use with an HSA, the embedded deductible must be selected only with individual deductibles of $2,800 ($5,600 for families) or higher.

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• LIFETIME MAXIMUM BENEFIT

Unlimited for essential health benefits (as defined by federal regulation)

The deductibles and out-of-pocket limits are based on the Consumer Price Index (CPI). Federal law requires an annual cost-of-living adjustment based on changes in the CPI; therefore, these plan designs may be adjusted annually.

[1]In- and out-of-network out-of-pocket limits and in- and out-of-network deductibles accrue separately, and accumulate according to the benefit period selected. The in-network out-of-pocket limit must be greater than the in-network deductible. However, if the 100/70 coinsurance option is selected, the in-network out-of-pocket limit and in-network deductible must be equal.

Covered Services

Medically necessary, eligible charges for the following services are payable under your self-funded health benefit plan design subject to the plan deductible, coinsurance and, for some out-of-network providers, Reasonable Fee[1].

Preventive Care Services

Covered preventive care services received in-network will be paid under your self-funded plan design at 100 percent[2] Age and frequency schedules apply. Some out-of-network services are subject to the plan deductible and coinsurance. Covered preventive care services include, but are not limited to:

- Routine physical exam
- Blood and other laboratory tests
- Screening ECG (electrocardiogram)
- Immunizations
- PSA (prostate-specific antigen)
- Colorectal cancer screening
- Screening for tobacco use
- Women's preventive services
  - Well-woman visits, including prenatal routine office visits
  - Mammograms: baseline and annual
  - Screening for cervical cancer
  - Contraceptive methods and counseling
  - Breastfeeding support, supplies and counseling

For a complete list of preventive care services, visit: www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. In no event will benefits for preventive care services be less than that which is required by state or federal law, as applicable.

Hospital and Provider Services

- Semiprivate hospital room, board and general inpatient nursing care
- Intensive care unit
- Miscellaneous services and supplies provided by a hospital on an inpatient basis
- Miscellaneous services and supplies provided by a hospital or free-standing surgical center and related to outpatient surgery or outpatient treatment of injury
- Anesthetics and their administration
- Physician's fees, except as otherwise noted
- Emergency services
- Telemedicine services

[1]Reasonable Fee is the lesser of the provider's actual charge, negotiated fee, or 150, 200 or 500 percent (depending on the service) of the Medicare reimbursement rate in effect at the time services are provided. Refer to the proposal for details.

[2]Preventive care benefits are in accordance with guidelines from the U.S. Preventive Services Task Force, Health Resources and Services Administration, and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Other Services and Supplies

- Prescription drugs (See page 6 for details on outpatient prescription drug benefits.)
- Blood and blood plasma, oxygen and rental of equipment for its administration
- Local licensed ambulance service to or from a hospital
- X-rays (not dental x-rays) and laboratory tests performed for diagnosis and treatment
- X-ray, cobalt, radioactive isotope therapy, radiation therapy, chemotherapy, and advanced imaging services, including but not limited to CT, CTA, MRA, MRI, NCI, PET, PET CT & 3D Rendering
- Artificial limbs and eyes
- Casts, splints, trusses, crutches and nondental braces
- Rental of a wheelchair, hospital-type bed or other durable medical equipment
- Habilitative and rehabilitative devices
- Normal maternity and nursery care, including complications of pregnancy
- Outpatient pre-admissions testing
- Hospice care
  - Maximum of 6 months while covered under this plan
- Home healthcare
  - Maximum of 100 days per year
- Skilled nursing care
  - Maximum of 81 days per year
- RN and LPN fees for private-duty nursing recommended by a physician
- Nondental treatment of temporomandibular joint dysfunction (TMJ)
- Chronic pain treatment programs
  - Maximum of 10 visits per year
- Hair prosthesis for alopecia resulting from cancer treatment that involves chemotherapy or radiation therapy
  - Maximum of one hair prosthesis per member, per year
- Gender dysphoria, excluding cosmetic services

Therapies

- Habilitative and rehabilitative services, including speech, occupational and physical therapist's fees, when prescribed by a physician
  - 60-visit limit per therapy, per year
- Manipulative therapy
  - 20-visit limit per year

Mental Illness, Nervous Disorders, Substance Abuse and Alcohol Abuse

Groups with up to 50 employees

- Outpatient expenses
  - 40-visit limit per year; 120 visits while covered under this plan
  - Covered charges are paid at 60 percent for an in-network provider (100 percent if the 100 in-network coinsurance is selected) ; 50 percent for an out-of-network provider.
- Inpatient expenses
- 20 days per year; 40 days while covered under this plan.
- Covered charges are paid according to the in- and out-of-network coinsurance selected.

Groups with 51 or more employees

- Outpatient and inpatient expenses
  - Covered charges are paid the same as any other covered service.

Organ Transplants

- Designated transplant facility
- Covered charges for approved transplant services, including organ procurement or acquisition, are paid at 100 percent.
- Coverage is provided for transportation, lodging and meals for a companion, subject to the following limits:
  a. Transportation benefit: maximum of $1,000 per approved transplant procedure
  b. Lodging and meals benefit: maximum of $250 per day; $10,000 while covered under this plan
- Nondesignated transplant facility
- Covered charges for approved transplant services at an out-of-network facility, including organ procurement or acquisition, are paid at 70 percent.
- No coverage is provided for transportation, lodging or meals for a companion.

Alternative Medicine

- Acupuncture, massage therapy and naturopathic services
  - 12-visit limit per therapy, per year
- Nutritional counseling
  - 3-visit limit while covered under this plan, except for diabetic counseling

Prescription Drug Benefit Choices Offer Flexibility

Covered Medications & Drug List Changes

All covered medications must be United States Food, Drug Administration (FDA) approved, and require a prescription. Covered prescription drugs are subject to the in-network plan deductible and coinsurance when the prescription is filled at a designated pharmacy.

The covered drug list is subject to change. New medications are excluded for 12 months to assess clinical effectiveness and formulary placement. If a member is impacted by a change in formulary, they will be notified, and alternative therapies will be outlined.

Keep Prescription Safeguards

To encourage the safe and appropriate use of prescription drugs, plan designs utilize quantity limits (30-day retail, 90-day mail order) and prior authorization for certain drug classes covered by the prescription benefit. Some specialty medications may have a lower quantity limit applied due to the way they are packaged or because they are a high-cost, high-risk medication. OhioHealthy assess effectiveness before allowing larger quantities to process. These limits and prior authorizations are intended to promote proper prescription utilization and clinically appropriate quantities.

Additionally, specialty pharmacy clinical guidelines are managed by Archimedes to help members receive the most appropriate specialty medication for managing their complex medical conditions.

Pharmacy Fulfillment Network

OhioHealthy has access to Express Scripts' large pharmacy network for both retail and specialty pharmacy. Prescriptions filled through in-network locations will process according to the plan design. Out-of-network pharmacies are not covered through and will be rejected at the point of sale.

Retail Medications

Express Scripts offers more than 60,000 in-network pharmacies for retail medications, including OhioHealth pharmacies and major retail partners like CVS and Walgreens. There is a 90-day mail order option for maintenance medications and specialty medications.

Specialty Medications

Archimedes provides high-quality clinical and safety programs designed for the unique needs of patients taking specialty medications. Specialty medications are generally prescribed for people with complex or ongoing medical conditions such as multiple sclerosis, hemophilia and rheumatoid arthritis. These medications can be filled locally through the OhioHealth specialty pharmacy and picked up in person or mailed to the member. If a medication is not available through OhioHealth, Archimedes will direct members to a specialty wrap network to ensure they are covered.

Copay Assist

Many specialty medications have copay assistance programs, where a drug manufacturer pays for part of the drug's cost in order to make it more affordable for patients. For covered medications, Archimedes will help members enroll in copay assistance so they can take advantage of these savings.

If a member fills a prescription for a specialty drug and uses a manufacturer copay assistance program to reduce their out-of-pocket cost for the drug, only the actual amount they pay will count toward their deductible and out-of-pocket maximum.

Affordable Care Act (ACA) Medications

The Affordable Care Act (ACA) requires non-grandfathered group health benefit plans to cover certain preventive medications at no additional cost. Coverage of any of the listed medications (including over-the-counter (OTC) medications) requires a prescription from a licensed health care provider. This list is subject to change as federal guidelines are updated or modified.

Vaccines

All members covered by the prescription plan are eligible to receive plan-covered vaccines at participating pharmacies. This does not include vaccines for travel purposes.

Cost-savings Features

Quality Virtual Care with Teladoc®

General Medical

Teladoc gives members 24/7 access to U.S. board-certified doctors via phone or video consults for nonemergency medical conditions. It's an affordable alternative to costly urgent care and ER visits when care is needed now.

Mental Health

With Teladoc's Mental Health services, adults 18 and older can get confidential treatment for anxiety, depression, grief, family issues and more. Members can choose their provider, schedule an appointment and speak with a therapist from anywhere in the U.S.

Note: In states where the age of majority is greater than 18 years, parental consent may be required.

Dermatology

Teladoc's licensed dermatologists can diagnose and treat common skin conditions like acne, eczema, psoriasis and more. Members simply request a consult, describe their symptoms and upload photos online or via the Teladoc app. A dermatologist will review their submission and send a custom treatment plan within two days.

Availability and services may vary by state. Teladoc consult fees are subject to the deductible and coinsurance, and are subject to change during the plan year.

PRECERTIFICATION

To avoid penalties, precertification is required for all non-emergency inpatient services, and several outpatient services, surgeries and procedures. Refer to the plan document for a full list of precertification requirements.

- To precertify, the member or the attending physician must follow the instructions provided on the medical identification card.
- Failure to precertify will result in a $300 penalty per occurrence. This penalty will not count toward the plan deductible, or toward the out-of-pocket limit.
- Precertification does not guarantee self-funded plan benefits are payable. The person must be eligible at the time of service.

EMERGENCY ADMISSIONS

Notification is required within 48 hours or the next business day of an emergency admission by calling the number shown on the ID card.

OUT-OF-NETWORK EMERGENCY CARE

The member responsibility for out-of-network emergency care will be calculated using the lesser of: the billed amount or Qualifying Payment Amount[1], which is generally the median of the applicable contracted rates. This amount will be applied to the in-network deductible and in-network out-of-pocket limit.

NOTICE AND CONSENT

Most out-of-network providers must notify a member that they are not in the patient's PPO network and obtain the patient's written consent before providing non-emergency care.

CONTINUITY OF CARE

In certain situations, if an in-network provider becomes an out-of-network provider, and the member is a continuing care patient, we will provide the member with notice and an opportunity to elect continuing care from such provider. This election will allow the member to continue to receive in-network benefits, beginning on the date of the notice and continuing until the earlier of: 90 days from the date of the notice; or the date on which the member is no longer a continuing care patient with the provider.

DEDUCTIBLE CREDIT FOR NEW GROUPS

A member continuously covered under a prior individual or group health plan with a calendar-year deductible will be credited for any portion of the deductible satisfied under the prior plan during the same calendar year. Only plan designs with a deductible greater than $0 are eligible to receive deductible credit. Deductible credit will not be given if moving to or from a health plan with a plan-year deductible.

Credit is not provided for out-of-pocket amounts (other than amounts applied to the deductible), prescription drug card deductibles or for employees added to a self-funded plan after the group's initial effective date.

LIMITED OCCUPATIONAL/24-HOUR COVERAGE

Sickness or injury which occurs while working for wage or profit is not covered, except for a member who is a sole proprietor, partner or executive officer of the company sponsoring a plan administered by OhioHealthy Health Insuring Corporation and Ohio Healthy Insurance Company, and who is not required by law to have Workers' Compensation or similar coverage and does not have such coverage.

ENROLLMENT

Annual Open Enrollment Period

Eligible employees may enroll themselves and their eligible dependents during the annual open enrollment period, which is the month prior to the start of the new plan year.

Waiting Period

The waiting period is the amount of time the employee must wait before he or she is eligible for coverage under your self-funded plan. The waiting period cannot exceed 90 days.

Timely Enrollees

Timely enrollees are eligible employees who complete and sign an Employee Eligibility Statement for themselves and/or their dependents during the employer's waiting period and prior to the end of the initial enrollment period. The initial enrollment period is the 31 days following the waiting period.

Special Enrollees

Special enrollees are employees or dependents who previously waived self-funded coverage, but may now be eligible because they have involuntarily lost their other coverage, had a benefit/coverage change or had a life-changing event. The enrollment period for a special enrollee is the 31 days following the special enrollment event (60 days for special enrollees who have lost their Medicaid or State Children's Health Insurance Program coverage). *Special guidelines apply for special enrollees.*

EARLY TERMINATIONS

1) If the administrative services agreement with OhioHealthy, Inc. terminates before the end of the contract period, the employer is responsible for funding all covered claims, below the specific deductible, if applicable, that were incurred and not processed while the agreement was in effect.

2) If the stop-loss insurance contract terminates before the end of the contract period, there is no aggregate stop-loss insurance available for the months the contract was in force. As a result, the employer is responsible for reimbursing Trustmark Life Insurance Company for any advances, including aggregate advances.

EXCLUSIONS AND LIMITATIONS

Major Medical

No benefits are payable under your self-funded health benefit plan design for the following expenses:

- Services and supplies not prescribed by a physician or required to treat a covered condition, or in excess of the Reasonable Fee[1], or not medically necessary
- Surgery of the jaw (orthognathic); dental care and treatment, including pediatric dental care and treatment; hearing aids[2], eyeglasses, eyeglass frames and contact lenses; eye or hearing exams[2]; all other vision care services; some foot treatment
- Cosmetic surgery; hair prosthesis, except as specified under Covered Services; hair transplants; treatment for weight reduction; treatment for abnormal male breast enlargement
- Charges the member is not legally required to pay; charges for missed or canceled appointments, stand-by charges or after hours; surcharges for weekend nonemergency office visits and home visits by a physician; treatment rendered by a member of the member's family; treatment, prescription drugs, services or supplies provided by a medical department, treatment center, pharmacy or clinic operated by or sponsored by a member's employer; occupational sickness and injury, except for members who are not covered by workers' compensation or similar coverage and are not required by law to have such coverage
- Treatment for infertility, except for services related to the diagnosis of infertility; pregnancy and all associated charges of a person who is not an eligible employee or dependent including, but not limited to, a surrogate; reversal of sterilization
- Non-prescription drugs[2]; imported drugs; any prescription drug containing bulk chemical powders; smoking deterrent medications[2]; restoration or enhancement of sexual activity
- Treatment received outside the United States, except emergencies; immunizations required for travel outside the United States; most treatment for snoring; excessive sweating; phonophoresis; surface electromyogram; therapeutic cold devices; x-rays or tests not related to diagnosis or treatment of sickness or injury, unless otherwise specified; treatment, services, supplies or prescription drugs designed or used to diagnose, treat, alter, impact, or differentiate genetic make-up or genetic predisposition, including but not limited to genetic therapy
- Most dietary supplements[2]; experimental/investigational drugs or treatment; items for comfort or convenience; expenses at a health spa; services and supplies related to homeopathic medicine; family or marriage counseling, aversion therapy, training or other forms of education, except as otherwise specified in the plan document; custodial care
- Suicide, attempted suicide or intentional self-inflicted injury, if not the result of a medical condition; injury resulting from one's own illegal use of alcohol, drugs or over-the-counter medications, if not the result of a medical condition
- Acts of war; participation in a riot; commission of or attempt to commit a felony; engaging in an illegal occupation

[1]Reasonable Fee is the lesser of the provider's actual charge, negotiated fee, or 150, 200 or 500 percent (depending on the service) of the Medicare reimbursement rate in effect at the time services are provided. Refer to the proposal for details.

[2]No benefits are payable under your self-funded plan design for these expenses, except as required under federal guidelines for preventive care.

PAIR YOUR PLAN WITH AN HSA

Freedom of Choice

By selecting a CDHP design, you can:

- Save on health plan costs by choosing the cost-savings feature of a high-deductible self-funded health benefit plan design compared to a traditional self-funded health benefit plan design.
- Design a self-funded plan with options that help attract and retain valued employees.
- Provide the self-funded plan on a stand-alone basis or pair it with a health savings account (HSA).
- Establish an HSA through any national or local administrator or financial institution that offers HSAs.

Ask your broker to help determine the self-funded health benefit plan design that best suits your business needs and budget.

WHAT IS AN HSA?

An HSA is a personal bank account owned by an individual with a high-deductible health benefit plan and used to pay for qualified medical expenses not reimbursed under the health plan.

WHY AN HSA?

Tax Advantages

Contributions to an HSA can be made by anyone and are either made pretax or are tax deductible. Any balances in the account are not taxed when used to pay for qualified medical expenses. Additionally, interest on the HSA grows tax deferred.

Note: Tax advantages vary by state.

Full-Year Contribution

Employees can open an HSA in any month and still have the ability to make the maximum annual contribution to the account, regardless of the effective date. Restrictions apply. Consult your financial advisor.

Portability

Funds roll over at the end of each year and belong to the employee, even when changing employers or switching to a different high-deductible health benefit plan.

Choice

Employees select how their HSA funds are spent and invested. Funds can also be accumulated to enhance a retirement portfolio.

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