
Basic and Standard Medical Plans for Eligible Individuals in Ohio



Central Reserve Life

CRL's Basic and Standard Plans for Eligible Individuals in Ohio

Ohio law requires that certain health insurance issuers may not decline to offer coverage to, or deny enrollment of, an Eligible Individual and may not impose any preexisting condition exclusions with respect to such coverage.

CRL has the Basic, Standard and Standard PPO plans available to Eligible Individuals in the State of Ohio. These plans are also available to our insureds who are terminating their coverage under a CRL employer group plan who are eligible for medical conversion and meet the definition of an Eligible Individual.

Eligible Individuals

An Eligible Individual is a person:

- (1) who, as of the date on which the individual seeks coverage, has been insured under Creditable Coverage [as defined by Ohio law] for at least eighteen (18) months and whose most recent period of coverage was under a group health plan (employer-sponsored plan), governmental plan, or church plan (or health insurance coverage offered in connection with any such plan); and
- (2) who is not eligible for coverage under:
 - (a) a group health plan (an employer-sponsored plan); or
 - (b) Part A or Part B of title XVIII of the Social Security Act (Medicare); or
 - (c) a state plan under title XIX of such Act (Medicaid or any successor program); and
- (3) does not have other health insurance coverage; and
- (4) whose most recent coverage was not terminated because of nonpayment of premiums or fraud; and
- (5) who is ineligible for COBRA or has elected and exhausted COBRA benefits (or continuation coverage under a similar state provision).

Creditable Coverage for Eligible Individuals

In general, Creditable Coverage [as defined by Ohio law] is coverage under any of the following, provided there was no more than a sixty-two (62) day break in coverage during all of which time period the individual was not covered (a waiting period shall not be treated as a break in coverage):

- (1) A group health plan (an employer-sponsored plan);
- (2) Health insurance coverage;
- (3) Part A or Part B of title XVIII of the Social Security Act (Medicare);
- (4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 (the program for distribution of pediatric vaccines);
- (5) Chapter 55 of title 10, United States Code (CHAMPUS);
- (6) A medical care program of the Indian Health Service or of a tribal organization;
- (7) A State health benefits risk pool;
- (8) A health plan offered under chapter 89 of title 5, United States Code (the Federal Employees Health Benefits Program);
- (9) A public health plan; or
- (10) A health benefit plan under section 5(e) of the Peace Corps Act [22 U.S.C. 2504(e)].

(Please note that not all insurance will be "Creditable Coverage," depending on applicable state and/or federal law. For example, coverage for a specified disease or illness, such as cancer, is not considered Creditable Coverage.)

If you believe you qualify as an Eligible Individual, your agent can assist you with enrollment in these plans.

Basic Plan

The benefit period under the Basic Plan is based on a calendar year.

Individual Calendar Year Deductible	\$1,000
Emergency Room Deductible*	\$75 per visit
Deductible for each Hospitalization not Precertified**	\$500
Coinsurance	50%
Individual Out-of-Pocket***	\$5,000
Outpatient Prescription drugs (per calendar year)	\$2,500
Maternity and Routine Nursery Care	Not Included
Calendar Year Maximum, per Insured Person	\$50,000

Standard Plan

The benefit period under the Standard Plan is based on a calendar year.

Individual Calendar Year Deductible	\$750
Emergency Room Deductible*	\$75 per visit
Deductible for each Hospitalization not Precertified**	\$500
Coinsurance	70%
Individual Out-of-Pocket***	\$5,000
Maternity and Routine Nursery Care	\$3,000
Outpatient Prescription Drugs (per calendar year)	\$2,500
Lifetime Maximum, per Insured Person	\$1,000,000

Standard PPO Plan

The benefit period under the PPO Plan is based on a calendar year.

Individual Calendar Year Deductible	\$750
Emergency Room Deductible*	\$75 per visit
Deductible for each Hospitalization not Precertified**	\$500
Coinsurance	80%– Plan Providers 60%– Non Plan Providers
Individual Out-of-Pocket***	\$3,000-Plan Providers \$5,000-Non Plan Providers
Maternity and Routine Nursery Care	\$3,000
Outpatient Prescription Drugs (per calendar year)	\$2,500
Lifetime Maximum, per Insured Person	\$1,000,000

* Waived for accidents or when the Insured Person is admitted to the hospital. This deductible is in addition to any other deductibles.

** In addition to any other deductibles.

*** The Individual Out-of-Pocket Maximum is in addition to any other deductible. Charges in excess of a specific dollar limit stated in the Covered Charges subject to limitation and General Exclusions sections cannot be used to satisfy any Coinsurance requirement.

COVERED CHARGES:

Covered Charges for the Basic, Standard and Standard PPO Medical Plans are subject to Deductible and Coinsurance.

■ **Maternity and Routine Nursery Care (Standard and PPO Plans only)**

Paid same as an illness. Includes dependent children.

■ **Hospital Room and Board**

Average Semi-private Room

Intensive Care Unit

3 times average semi-private rate

■ **Mental/nervous/alcoholism and drug addiction**

Lifetime Maximum, per person

Basic Plan \$5,000

Standard and Standard PPO Plans \$10,000

Calendar Year Maximum, per person

Inpatient..... \$2,000

Outpatient..... \$550

Eligible Charge \$50 per visit

■ **Organ Transplants**

Lifetime Maximum, per Insured Person \$100,000

Covered Transplants Heart, Heart/lung, Lung, Liver, Bone Marrow, Kidney, Pancreas and Cornea

Covered Charges Initial testing & diagnosis; Immunosuppressant drug therapy before and after surgery; Complications resulting from surgery, organ rejection/failure; Repeat transplants of same organ. No other organ transplants are covered.

■ **Skeletal Adjustment/adjunctive therapy/vertebral manipulation/ dislocation-subluxation services**

Eligible Charge \$25 per visit

Maximum visits per year, per Insured Person 10

■ **Outpatient Physical Therapy**

Eligible Charge \$40 per visit

Maximum visits per year, per Insured Person 20

■ **Preventive Care**

Child Wellness Benefit

Calendar Year Maximum, per child

Birth to age one \$500

Ages one through eight \$150

Mammogram, per person \$85

Age 35 through 39 One Mammogram

Age 40 through 49 One Mammogram every two years or one per year if woman has risk factors for breast cancer

Age 50 through 64 One Mammogram per year

Pap Smear Covered

■ **Outpatient Prescription Drugs**

Calendar Year Maximum, per Insured Person \$2,500

- **Nursing Home, Convalescent Home, Extended Care Facility, Home Health Care and Hospice**
Calendar Year Maximum, per Insured Person \$5,000
- **Purchase or rental (whichever costs less) of durable medical equipment for temporary use, not to exceed a six-month period.**
- **In the event an assisting surgeon is medically necessary to assist in performance of an operation, the maximum benefit shall not exceed 20% of all eligible charges made by the surgeon performing the operation.**
- **If two or more procedures are performed in the same operative session, the maximum payment shall be limited to:**
 - a. if two or more procedures are performed through the same incision, payment shall be limited to the amount payable for the procedure having the greater payment.
 - b. payments shall be limited to the amount payable for the procedure having the greater payment plus one-half of the amount that would have otherwise been payable for the procedures having the lesser benefit.
- **Complications of pregnancy.**

A complication of pregnancy is a condition that is distinct from pregnancy, but is adversely affected by pregnancy. Examples of such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, and conditions of comparable severity. It also includes conditions such as emergency nonelective caesarean section, ectopic pregnancy, hyperemesis gravidarum, and spontaneous abortion occurring when a viable birth is not possible.

It does NOT include: false labor, occasional spotting, physician-prescribed rest during pregnancy, morning sickness, pre-eclampsia, or other conditions related to a difficult pregnancy.

GENERAL EXCLUSIONS

No benefits will be paid for charges:

1. For transportation, except local, to or from a Hospital, by professional ground ambulance service.
2. For normal childbirth, normal pregnancy or routine nursery care (except as provided in the Schedule of Benefits), elective caesarean section or voluntarily induced abortion.
3. For fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for any Treatment related to or connected in any way with the restoration or enhancement of fertility or the inability to conceive or conception by artificial means, including, but not limited to, in-vitro fertilization or embryo transfer.
4. For replacement of artificial limbs and artificial eyes.
5. For blood or blood plasma which has been replaced.
6. For donation of any body organ by an Insured Person.
7. For services performed by a person who ordinarily resides in the Insured Person's home or is a Close Relative of the Insured Person or by the Insured Person's Employer or partner.
8. For any cosmetic surgery, unless required to restore a part of the body which has been altered as a result of the following events or conditions that occurred while the Insured Person was insured by the Policy and for which benefits were paid in accordance with the terms of the Policy.
 - a. Accidental bodily injury;
 - b. Surgery; or
 - c. Disease that was first diagnosed while the Insured Person was insured by the Policy.
9. For Custodial Care.
10. Applied to a Deductible or Coinsurance amount under any benefit of the Policy.
11. For services or Treatment not prescribed by a Doctor or for services or Treatment not shown as covered.
12. Due to an Illness arising out of, or in the course of, employment for wages or profit.
13. For expenses incurred after the insurance terminates
14. For Treatment or services Experimental or Investigational in nature.
15. For eye refractions, eyeglasses, or contact lenses, including fittings and examinations, or eye surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including, but not limited to radial keratotomy.
16. For Treatment, services or supplies furnished by a department or agency of the United States Government. This exclusion will not apply to a non-service connected Illness of a veteran of the United States armed forces who does not have a service connected Illness.
17. For services and supplies eligible for payment by a governmental or charitable program, except as required by law.
18. For hearing aids, including fittings and examinations.
19. Which are not Necessary to the care or Treatment of an Illness.
20. Which would not have been made if no insurance existed.
21. For recreational or educational therapy or vocational rehabilitation.
22. Except as allowed under Covered Charges Subject To Limitations, for speech or occupational therapy and related diagnostic testing if the therapy or testing is in connection with or related in any way to the Treatment of a learning disability, speech impediment, or developmental delay even though therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma.
23. For which the Insured Person is not legally obliged to pay.
24. For Treatment or services which are not generally accepted medical practices in the United States for a given Illness.
25. For Treatment of obesity, morbid obesity or for weight reduction purposes.
26. For Illness that results from participation in any assault, unlawful act, strike, civil disorder or riot.
27. For the Treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and the implantation of a penile prosthesis.
28. For routine physical or premarital examination except as may be covered under the Child Wellness Benefit. Mammograms and pap smears are covered.

29. No benefits will be paid for charges due to a Preexisting condition. This limitation relates only to conditions treated during the six months immediately preceding the effective date of coverage. Benefits will be paid for such charges incurred after the end of a period of twelve (12) consecutive months while insured under the Policy. This exclusion does not apply to federally Eligible Individuals.
30. For a private room in excess of the average semi-private Room and Board rate.
31. In excess of Reasonable and Customary charges.
32. For services or supplies prohibited by law.
33. For sex changes.
34. For sterilization and reversal of sterilization.
35. Resulting from any suicide, attempted suicide or intentionally self-inflicted Injury or Sickness while sane or insane.
36. For examination, Treatment or surgery of the teeth, gums or direct supporting structure, except for repair of Injury to sound natural teeth, (including their replacement) as a result of an accidental bodily injury which occurs while the person is insured. Treatment must be given within ninety (90) days of the date of the accident.
37. For an Illness caused by any act of war, whether or not declared.
38. For Surrogate Pregnancy.
39. For surgery of the jaw or for any Treatment of temporomandibular joint (TMJ) disorder. Treatment of jaw fractures and removal of tumors of the jaw will not be subject to this exclusion.
40. For the Treatment of complications arising from or connected in any way with a surgical or medical Treatment or procedure that is not a covered surgical or medical Treatment or procedure under the terms of the Policy, whether or not the Insured Person was insured under the Policy at the time the non-covered Treatment or procedure was performed.
41. For foot care due to:
 - a. Treatment of weak, strained or flat feet or instability or imbalance of the foot.
 - b. Treatment of corns, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other Illnesses of similar medical seriousness.
42. For contraceptives, infertility drugs and growth hormones.

Important Information for the Ohio Basic, Standard and Standard PPO Plans

How Eligible Individuals May Enroll for Coverage

CRL must receive the application for the Eligible Individual in its Home Office within sixty-two (62) days of the date the Individual's coverage under his/her former employer's group health plan (an employer-sponsored plan) terminated.

TO ENROLL FOR COVERAGE

The following must be completed in full and given to the agent for submission to the Home Office:

1. Individual Member Application for Eligible Individuals (APL-GRP49B) or, if converting, Eligible Individual Application for Conversion (APL-0097).
2. Check for first month's premium.
3. Copies of all Certifications of Creditable Coverage for each Individual and Dependent applying as Eligible Individuals, if available. Attach the certifications to the Application. If an applicant with prior coverage does not have a copy of his/her Certification of Creditable Coverage, CRL may be able to assist the individual in obtaining this information.
4. The effective date of coverage will be the date the application is received in CRL's Home Office or the first day following the termination of the person's prior coverage, whichever is later.

No agent has authority to change any benefits or bind coverage with Central Reserve Life, or to promise a certain effective date.

CRL reserves the right to rescind, cancel or terminate coverage for any individual who is found to have fraudulently misrepresented any answer or information during verification or on an enrollment application or Health History Questionnaire.



Central Reserve Life

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