

### **317:45-1-4. Reimbursement for out-of-pocket medical expenses**

[Issued 9-1-06]

(a) O-EPIC members are responsible for all out-of-pocket expenses. Out-of-pocket expenses for services covered by the health plan, as defined by the health plan's benefit summary and policies, that exceed 5% of the employee's gross annual household income during the current eligibility period may be reimbursable.

(b) The O-EPIC member must submit a reimbursement claim form with appropriate documentation to the TPA. Information may be submitted at any time but no later than 90 days after the close of their eligibility period. Appropriate supporting documentation includes an original EOB or paid receipt if no EOB is issued. Both EOB and paid receipts must include required information listed in OAC 317:45-5-1(c)(1)-(6). Reimbursement for out-of-pocket medical expenses is made for the amount indicated as the member's responsibility on the EOB or receipt reflecting the amount paid for medical expenses. Appropriate supporting documentation for prescribed prescriptions must be an original receipt and include information about the pharmacy at which the drug was purchased, the name of the drug dispensed, the quantity dispensed, the prescription number, the name of the person the drug is for, the date the drug was dispensed and the total amount paid.

(c) Reimbursement for qualified medical expenses is subject to a fixed cap amount. The fixed cap for reimbursement is established annually and is calculated using local and national data concerning individual out-of-pocket health care expenses. The objective of the fixed cap is to set the amount high enough such that, in the great majority of households, all of the costs above the 5% threshold would be absorbed.

#### **OAC 317:45-5-1(c)(1)-(6).**

(c) Qualified Health Plans may provide an Explanation of Benefits (EOB) for paid or denied claims subject to member co-insurance or member deductible calculations. If an EOB is provided it must contain, at a minimum, the:

- (1) provider's name;
- (2) patient's name;
- (3) date(s) of service;
- (4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
- (5) reason code(s) and description(s) for any denied service(s); and
- (6) amount due and/or paid from the patient or responsible party.