AULTCARE: FEHB Program HDHP Option PPO

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage **Coverage for: Self Only, Self Plus One or Self and Family** **Plan Type: PPO**

This is only a summary. Please read the FEHB Plan brochure RI 73-699 that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at www.aultcare.com/fehb or by calling 330-363-6360 or 1-800-344-8858.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-Network:** $2,000 Self $4,000 Self Plus One $4,000 Self and Family **Out-of-Network:** $4,000 Self $8,000 Self Plus One $8,000 Self and Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain covered services you use. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible** and for which services are subject to the calendar year deductible.
Are there other deductibles for specific services?	No	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	**In-Network**: $4,000 Self $8,000 Self Plus One $8,000 Self and Family **Out-of-Network:** $8,000 Self $16,000 Self Plus One $16,000 Self and Family	The **out-of-pocket limit**, or **catastrophic maximum**, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses. Your out-of-pocket expenses may be decreased through the Health Reimbursement Account (HRA) or Health Savings Account (HSA).
What is not included in the out–of–pocket limit?	Penalties, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes For a list of network providers, see www.aultcare.com/fehb or call 330-363-6360 or 1-800-344-8858.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

*The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference.

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OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See this plan's Federal brochure for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance *	--none--
	Specialist visit	20% coinsurance	40% coinsurance *	--none--
	Other practitioner office visit	20% coinsurance	40% coinsurance*	--none--
	Preventive care/screening/immunization	No charge	50% coinsurance*	Coverage is provided for routine annual exams.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance*	--none--
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance*	--none--

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aultcare.com/fehb	Generic/Brand/Specialty drugs	20% coinsurance	20% coinsurance	In-network deductible applies to out-of-network providers. A 34-day supply is available at the retail pharmacy. A 90-day supply may be obtained through the mail order program. You may receive up to a 30 day supply of Specialty Medications at retail and mail order. If a prescription is purchased without using your card, AultCare will pay up to our liability of Usual, Customary or Reasonable (UCR) or Contracted Rate only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance*	--none--
	Physician/surgeon fees	20% coinsurance	40% coinsurance*	--none--
If you need immediate medical attention	Emergency room services	20% coinsurance	40% coinsurance*	--none--
	Emergency medical transportation	20% coinsurance	20% coinsurance*	In-network deductible applies to out-of-network providers
	Urgent care	20% coinsurance	40% coinsurance*	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance*	Precertification required.
	Physician/Surgeon fee	20% coinsurance	40% coinsurance*	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health outpatient services	20% coinsurance	40% coinsurance*	--none--
	Mental/Behavioral Health inpatient services	20% coinsurance	40% coinsurance*	Precertification required.
	Substance Use Disorder outpatient services	20% coinsurance	40% coinsurance*	--none--
	Substance Use Disorder inpatient services	20% coinsurance	40% coinsurance*	Precertification required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance*	--none--
	Delivery and all inpatient services	20% coinsurance	40% coinsurance*	Precertification may be required

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home Health Care	20% coinsurance	40% coinsurance*	Precertification required. Coverage is limited to 60 visits per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance*	Coverage for outpatient speech, physical, occupational therapy is limited to 60 visits each per calendar year.
	Habilitation services	20% coinsurance	40% coinsurance*	Coverage includes, but is not limited to, the diagnosis of Autism Spectrum Disorder for children age 0-21. Services are limited to: Speech, Language and Occupational Therapy - 60 visits per calendar year; Therapies for Applied Behavioral Analysis - 20 hours per week and Mental/Behavioral Health Outpatient Services.
	Skilled nursing care	20% coinsurance	40% coinsurance*	Precertification required.
	Durable Medical Equipment	20% coinsurance	40% coinsurance*	Precertification required.
	Hospice service	20% coinsurance	40% coinsurance*	Precertification required.
If your child needs dental or eye care	Eye exam	No charge	50% coinsurance*	Coverage is limited to eye exams through age 17.
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care – (except Accidental injury and Cataract Surgery -Adult)
- Routine foot care (except when under treatment for metabolic or peripheral vascular disease such as diabetes)
- Weight loss programs
- Abortion (except when the life of the mother would be endangered or when the pregnancy is the result of an act of rape or incest)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy with the plan, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan Brochure, contact your HR office/retirement system, contact your plan at 330-363-6360 or 1-800-344-8858 or visit www.opm.gov.insure/health.

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Your Appeals Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For information about your **appeal** rights, please see Section 4, "How you get care," and Section 9 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: AultCare Customer Service Center at 330-363-6360 or 1-800-344-8858 or send your **appeal** in writing to our Grievance and Appeal Coordinator at P.O. Box 6029, Canton, Ohio 44706-0910.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 330-363-6360 /1-800-344-8858.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 330-363-6360 /1-800-344-8858.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 330-363-6360 / 1-800-344-8858.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 330-363-6360 / 1-800-344-8858.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,440
- **Patient pays** $3,100

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$1,070
Limits or exclusions	$30
Total	**$3,100**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,670
- **Patient pays** $2,730

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$650
Limits or exclusions	$80
Total	**$2,730**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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