The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. 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. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure at www.aultcare.com/fehb and view the Glossary at www.aultcare.com/fehb. You can call 330-363-6360 or 1-800-344-8858 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0 / Self Only $ 0 / Self Plus One $ 0 / Self and Family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Network medical services are not subject to a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$ 6,850 / Self Only $ 13,700 / Self Plus One $ 13,700 / Self and Family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See www.aultcare.com/fehb or call 330-363-6360 or 1-800-344-8858 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copayment/visit	Not covered	None
	Specialist visit	$20 copayment/visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	PCP: $15 copayment; Specialist: $20 copayment; Outpatient facility: $50 copayment	Not covered	None
	Imaging (CT/PET scans, MRIs)	PCP: $15 copayment; Specialist: $20 copayment; Outpatient facility: $50 copayment	Not covered	Preauthorization is required for certain radiology studies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aultcare.com/fehb	Generic drugs (1st Tier)	Retail: $10 copayment; Mail Order: $27 copayment		A 34-day supply is available at the retail pharmacy. A 90-day supply may be obtained through the mail order program. Specialty/Limited Distribution medications are limited to a 30 day supply retail and mail order. If a prescription is purchased without using your card, AultCare will pay up to the allowed amount. Once your out-of-pocket maximum is reached, your copayment will be $0.
	Brand drugs (2nd Tier)	Retail: $20 copayment or 30% coinsurance, whichever is greater, up to a maximum of $350; Retail/Mail Order: $55 copayment or 25% coinsurance, whichever is greater, up to a maximum of $350		
	Brand drugs (3rd Tier)	Retail: $45 copayment or 50% coinsurance, whichever is greater, up to a maximum of $350; Mail order: $120 copayment or 45% coinsurance, whichever is greater, up to a maximum of $350		
	Brand drugs (4th Tier)	Retail or Mail order: $125 copayment or 20% coinsurance, whichever is greater, up to a maximum of $350		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copayment/visit	Not covered	Preauthorization is required for certain surgical procedures.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$50 copayment/visit	$50 copayment/visit	Copayment waived if admitted. Charges from an Out-of-Network Provider may be subject to balance billing.
	Emergency medical transportation	No charge	No charge	Charges from an Out-of-Network Provider may be subject to balance billing. Preauthorization is required for Non-Emergent ambulance transportation.
	Urgent care	$50 copayment/visit	$50 copayment/visit	Charges from an Out-of-Network Provider may be subject to balance billing.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copayment/admission	Not covered	Preauthorization is required.
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office:** $20 copayment/visit; **Outpatient:** No charge	Not covered	Preauthorization is required for Partial Hospitalization and Intensive Outpatient Programs.
	Inpatient services	$150 copayment/admission	Not covered	Preauthorization is required.
If you are pregnant	Office visits	No charge	Not covered	Depending on the type of services, a copayment may apply.
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	$150 copayment/admission	Not covered	Preauthorization is required.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Preauthorization is required.
	Rehabilitation services	**Office/Outpatient:** $20 copayment/visit; **Inpatient:** No charge	Not covered	Coverage for outpatient Occupational, Physical, and Speech Therapy is limited to 60 visits each per calendar year.
	Habilitation services	**Office/Outpatient:** $20 copayment/visit; **Inpatient:** No charge	Not covered	Coverage includes, but is not limited to, the diagnosis of Autism Spectrum Disorder. 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	No charge	Not covered	Preauthorization is required.
	Durable medical equipment	No charge	Not covered	Preauthorization is required for any item greater than $1,000.
	Hospice services	No charge	Not covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$20 copayment/visit; plus all charges over maximum plan payments	Not covered	Coverage is limited to eye exams through age 17. Also refer to Vision Plan for additional coverage details.
	Children's glasses	Various payments	Not covered	Refer to Vision Plan for coverage details.
	Children's dental check-up	30% coinsurance	Not covered	Refer to Dental Plan for coverage details.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Long-term care
- Routine eye care (Adult)
- Routine foot care (except when under treatment for metabolic or peripheral vascular disease such as diabetes)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)

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

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. 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. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and 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 3, "How you get care," and Section 8 "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 plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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 section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$150
Other copayment	varies

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$190
Coinsurance	$0
What isn't covered	
Limits or exclusions	$260
The total Peg would pay is	$450

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$150
Other copayment	varies

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$650
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$710

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$150
Other copayment	varies

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$120

The plan would be responsible for the other costs of these EXAMPLE covered services.

AultCare/Aultra Notice Tag Lines for the State of Ohio

English
This Notice has Important Information**.** This notice has important information about your application or coverage through **AultCare /Aultra.** Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. **Call Local: 330.363.6360 Outside Stark County: 1.800.344.8858 TTY Local: 330.363.2393 Outside Stark County: 1.866.633.4752**

Spanish
Español
Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través **AultCare/Aultra.** Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al **Local : 330.363.6360 Fuera del condado de Stark : 1.800.344.8858 TTY Local : 330.363.2393 Fuera del condado de Stark : 1.866.633.4752**

Chinese
中文
本通知有重要的訊息。本通知有關於您透過 **AultCare/Aultra 保險公司**
提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用
補貼。您有權利免費以您的母語獲得幫助 **330.363.6360 斯塔克縣外幫助 1.800.344.8858 TTY 線 本地： 330.363.2393 斯塔克縣外： 1.866.633.4752。**

German
Deutsche
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch **AultCare/Aultra**. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY –Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752.**

Arabic
لا عربي
هذا الإشعار يحتوي على معلومات هامة. هذا الإشعار يحتوي على معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال شركة التأمين AultCare/Aultra ابحث عن المواعيد الهامة في هذا الإشعار. قد تحتاج إلى اتخاذ إجراء في غضون مواعيد نهائية معينة للحفاظ على تغطيتك الصحية أو المساعدة في تغطية التكاليف. لك الحق في الحصول على المعلومات الهامة في لغتك الأصلية مجانًا. اتصل بـ 330.363.6360 لخط خارج مقاطعة ستارك: 1.800.344.8858 لخط TTY المحلي: 330.363.2393 لخط خارج مقاطعة ستارك: 1.866.633.4752

Pennsylvania Dutch
Deitsch
Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit **AultCare/Aultra**. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY – Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752**.

Russian
русский
Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через **Страховая компания AultCare/Aultra**. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону **Местный: 330.363.6360 Вне Старка County : 1.800.344.8858 TTY линия Местный: 330.363.2393 Вне Старка County : 1.866.633.4752.**

French
Français
Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de **Compagnie d'Assurance AultCare/Aultra**. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. **Appelez Locale: 330.363.6360 En dehors du comté de Stark : 1.800.344.8858 ligne ATS Local : 330.363.2393 En dehors du comté de Stark :1.866.633.4752**

Vietnamese
Việt Nam
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình **Công ty Bảo hiểm AultCare/Aultra**. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số **Địa phương: 330.363.6360 Bên ngoài của Stark County : 1.800.344.8858 TTY đường dây Địa phương: 330.363.2393 Bên ng oài của Stark County : 1.866.633.4752.**

Cushite-Oromo
Beeksisni kun odeeffannoo barbaachisaa qaba**.** Beeksisti kun sagantaa yookan karaa **AultCare/Aultra** tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa **Local: 330.363.6360 Outside of Stark County: 1.800.344.8858 TTY Line Local: 330.363.2393 Outside of Stark County: 1.866.633.4752** tii bilbilaa.

Korean
한국어
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 **AultCare/Aultra 보험 회사계획** 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. **지역 : 330.363.6360 스타크 카운티 의 외부 : 1.800.344.8858 TTY 라인 지역 : 330.363.2393 스타크 카운티 의 외부 : 1.866.633.4752** 로 전화하십시오.

Italian
Italiano
Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso **AultCare/Aultra**. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama **Locale: 330.363.6360 Al di fuori di Stark County : 1.800.344.8858 TTY linea Locale: 330.363.2393 Al di fuori di Stark County : 1.866.633.4752.**

Japanese
日本語
この通知には重要な情報が含まれています。この通知には AultCare/Aultra 保険会社 の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。330.363.6360 スターク郡の外： 1.800.344.8858 TTY ライン ローカル： 330.363.2393 スターク郡の外： 1.866.633.4752 までお電話ください。

Dutch
Nederlands
Deze mededeling heeft belangrijke informatie. Deze mededeling heeft belangrijke informatie over uw aanvraag of dekking via **AultCare /Aultra.** Kijk naar belangrijke datums in deze mededeling. Het kan nodig zijn om actie te ondernemen binnen bepaalde termijnen om uw zorgverzekering te behouden of hulp met kosten te krijgen. U heeft het recht op deze informatie en hulp in uw taal zonder kosten. Bel **Local : 330.363.6360 Buiten Stark County : 1.800.344.8858 TTY Line Local : 330.363.2393 Buiten Stark County : 1.866.633.4752.**

Ukrainian
український
Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через **Страхова компанія AultCare/Aultra.** Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону **Місцевий : 330.363.6360 Поза Старка County : 1.800.344.8858 TTY лінія Місцевий : 330.363.2393 Поза Старка County : 1.866.633.4752.**

Romanian
Română
Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin **Compania de Asigurari AultCare/Aultra**. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la **Locale : 330.363.6360 In afara Stark Judet : 1.800.344.8858 TTY linie Locale : 330.363.2393 In afara Stark Judet : 1.866.633.4752.**

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