AultCare Health Plan

www.aultcare.com

Customer Service (1-800-344-8858) or (330-363-6360)

AULTCARE

2015

A Health Maintenance Organization (high option) and a high deductible health plan

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See pages 4 & 8 for details.

Serving: *Stark, Carroll, Holmes, Tuscarawas and Wayne counties and the Canton Metropolitan area in Ohio*

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 15
- Summary of benefits: Page 114

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 15 for requirements.

Enrollment codes for this Plan:

3A1 High Option– Self Only
3A2 High Option – Self and Family

3A4 High Deductible Health Plan (HDHP) Option – Self Only
3A5 High Deductible Health Plan (HDHP) Option – Self and Family

HEALTH PLAN NCQA ACCREDITATION EXCELLENT
COMMERCIAL HMO

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-699

Important Notice from AultCare Health Plan About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Aultcare Health Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your Aultcare Health plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 - December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048).

Table of Contents

Introduction

This brochure describes the benefits of under our contract (CS 2723) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1 (800)-344-8858 or through our website: www.aultcare.com. The address for AultCare Health Plan administrative office is:

AultCare Health Plan
2600 Sixth Street SW
Canton, Oh 44710

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means AultCare Health Plan**.**
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.

- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-800-204-5119 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise);
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage(i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligble to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5.Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precuations.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use *AultCare* preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Minimum essential coverage (MEC)

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

Minimum value standard

Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/healthcare-insurance for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies that participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends;
- When the next Open Season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLE's, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

Family member coverage

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren (including qualified children of same-sex domestic partners in certain states) are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2015 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2014 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family nenber are no longer elgible to use your health insurance coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

Upon divorce

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc. You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

Finding replacement coverage

This plan no longer offers its own non-FEHB plan for conversion purposes. If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 330-363-6360 or 1-800-344-8858 or visit our website at www.aultcare.com.

Health Insurance Marketplace

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO) with a high deductible health plan (HDHP) option. The HMO will require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments described in this brochure. When you receive emergency services from Non-Participating providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

This plan is a "grandfathered health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed-dollar amount you pay) must be minimal.

Questions regarding what protections apply may be directed to us at AultCare: 1-800-344-8858. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles, or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

You are eligible for a Health Savings Account (HSA) if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term care coverage), not enrolled in Medicare, not received VA or Indian Health Services (HIS) benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.

- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection (HDHP)

We protect you against catastrophic out-of-pocket expenses for covered services. When you use network providers, your annual out-of-pocket expenses for covered services, including deductibles, coinsurance and copayments, cannot exceed $4,000 for Self-Only enrollment, or $8,000 for Self and Family coverage.

We have network providers

Our AultCare Health Care Plan offers services through a network. When you use our network providers, you will receive covered services at reduced cost. AultCare is solely responsible for the selection of network providers in your area. Contact us for the names of network providers and to verify their continued participation. You can also go to our Web page, which you can reach through the FEHB website, www.opm.gov/healthcare-insurance. Contact AultCare to request a network provider directory.

In-network benefits apply only when you use a network provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas.

How we pay providers

HMO Providers: We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments.

AultCare HMO is an IPA model HMO, whereby the HMO has individual agreements with select physicians who have agreed to provide care for AultCare HMO enrollees. Each family member must select a primary care doctor who coordinates care for the HMO enrollee. There are approximately 251 primary care physicians from which to choose and nearly 642 specialists in our network.

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from this Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when their has been a referral by the member's primary care doctor with the following exception(s): a woman may see her Plan gynecologist for her annual routine examination without a referral.

PPO Providers: Allowable benefits are based upon charges and discounts which we or our PPO administrators have negotiated with participating providers. PPO provider charges are always within our plan allowance.

Non-PPO providers: We determine our allowance for covered charges by using health care charge data prepared by the Health Insurance Association of America (HIAA) or other credible sources, including our own data, when necessary.

Health education resources and accounts management tools

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- AultCare has been in existence since 1985
- AultCare is a for-profit organization

If you want more information about us, call 1-800-344-8858 or visit our website at www.aultcare.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescritpion drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live or workin our service areas. This is where our network providers practice. Our Service Areas are:

• Stark

• Carroll

• Holmes

• Tuscarawas

• Wayne Counties in Ohio

• Canton metropolitan area in Ohio

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If a dependent lives out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or another plan that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2015

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to HMO only

- Your share of the non-Postal premium has increased for Self-Only and for Self and Family.
- Prescription drugs - The plan increased the copayments on each prescription drug tier. The purpose is to continue to provide cost-effective benefits and to continue to meet the generic and specialty drug trends. See page 50.

Changes to our High Deductible Health Plan

- Your share of the non-Postal premium has increased for Self-Only and for Self and Family.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-344-8858 or write to us at 2600 Sixth Street SW, Canton, OH 44710**.** You may also request replacement cards through our website: www.aultcare.com

Where you get covered care

HMO Option: You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, and you will not have to file claims.

HDHP Option: You will only pay deductibles and coinsurance and you will not have to file claims.

You get care from "Plan providers" and "Plan facilities." You can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physican or by another participating provider in the network.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Website.

- **Out-of-network providers and facilities**

Better Plan benefits are available when you use AultCare Providers. In order to receive maximum Plan benefits, you must use the services of Aultman Hospital and the Physicians within the AultCare network. If, on the other hand, you use a Non-AultCare Provider, lesser benefit amounts may be payable. Should you be referred by an AultCare Provider to a Non-AultCare Provider, and the referral is approved by AultCare, benefits are payable as if provided by an AultCare Provider up to the Usual, Customary and Reasonable (UCR) fee. If the referral is not approved by AultCare, you will be subject to a reduction in benefits.

What you must do to get covered care

HMO Option: It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

HDHP Option: You can get care from any “covered provider” or “covered facility.” How much we pay – and you pay – depends on the type of covered provider or facility you use. If you use our preferred providers, you will pay less.

- **Primary care**

HMO Option only: Your primary care physician can be a family practitioner, internist, and pediatrician.Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

HMO Option: Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see *obstetrician/gynecologist without a referral.*

Here are some other things you should know about specialty care:

• If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care physician will use our criteria when creating your treatment plan. The physician may have to get an authorization or approval beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist.

If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

• If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

• If you have a chronic and disabling condition and lose access to your specialist because we:

– terminate our contract with your specialist for other than cause;

– drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or

– reduce our service are and you enroll in another FEHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

HMO Option: Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-344-8858. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB Plan to us, your former Plan will pay for the hospital stay until:

• you are discharged, not merely moved to an alternative care center;

• the day your benefits from your former Plan run out; or

• the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your Plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new Plan begin on the effective date of enrollment.

HDHP Option: We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our HDHP begins, call our Customer Service department immediately at 330-363-6360 or 1-800-344-8858.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Transplants
- Partial hospitalization programs provided out-of-network;
- Intensive outpatient programs provided out-of-network;
- Home health care referred by out-of-network providers;
- Rehabilitation facility admissions;
- Skilled nursing facility admissions;
- Hospice Care;
- Physical, occupational, speech, cognitive and growth hormone therapies;
- Mental Health and Substance Abuse; and
- Certain Drugs
- BRCA/BART testing

How to get approval for…

- **How to precertify an admission**

HMO Option: Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process precertification. Precertification is required for all non-AultCare admissions and all Home Health Care programs. You must notify the AultCare Utilization Department prior to any planned non-AultCare admissions or to any Home Health Care program.

Other services requiring precertification include:

• Partial hospitalization programs provided out-of-network;

• Intensive outpatient programs provided out-of-network;

• Home health care referred by out-of-network providers;

• Rehabilitation facility admissions;

• Skilled nursing facility admissions;

• Hospice Care;

• Physical, occupational, speech, cognitive and growth hormone therapies;

• Mental Health and Substance Abuse; and

• Certain Drugs

HDHP Option:The process known as pre-certification is an evaluation of your medical case by your provider and AultCare medical professionals to determine the appropriateness of your Hospital admission and expected length of stay. In some cases, an alternative to Hospital admission, such as outpatient treatment, may be recommended.

If your medical professional is an AultCare Provider, the pre-certification process will be handled for you by your provider when required. You are only responsible for alerting your provider that you are an AultCare participant. However, if your medical professional is not an AultCare Provider, you are responsible for seeing that utilization review procedures are followed. Contact the Utilization Review Department or the Service Center at 330-363-6360 or 1-800-344-8858. The Utilization Review Department will handle pre-certification and tell you if a second opinion is necessary for the procedure being done and encourages out patient surgery when medically necessary.

Depending on the circumstances and time constraints of your situation, you may be asked to have a form completed. When possible, utilization requirements will be met with a simple phone call by the Utilization Review Department to your Doctor.

Failure to meet pre-certification requirements for Non-Panel Hospital admissions will result in a reduction of benefits.

How to request precertification or give prior authorization for Other Services

First, your physician, your hospital, you, or your representative, must call us at 330-363-6360 or 1-800-344-8858 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent Care Claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800-344-8858. You may also call OPM's Health Insurance 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-800-344-8858. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approval time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need to precertify your normal delivery. You may remain in the hospital for up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. See Section 5(a) for more information.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

- **Circumstances beyond our control**

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

- **Services requiring our prior approval**

Upon occasion, it may be necessary for your AultCare Provider to refer you to a Physician outside the AultCare Network. In order for you to receive the greatest benefit possible from your AultCare Plan, the following procedure must be followed:

Your AultCare Provider must contact the pre-admission coordinator at the AultCare Utilization Management Department to explain the circumstances of the referral. This can be done by telephone or by completing a referral form available to the Physician.

The completed referral request will be reviewed by the AultCare Medical Director. You and your Physician will be contacted directly as to whether the referral has been approved. If you do not receive written confirmation of your referral, please contact the AultCare Utilization Management Department at 330-363-6360 or 1-800-344-8858 prior to your appointment at the Non-AultCare Provider. When a referral is approved, benefits will be payable as outlined for other AultCare Providers, subject to UCR limitation.

When a referral is not approved, or the above procedure is not followed, benefits are payable as outlined for other Non-AultCare Providers.

Case Management: The goal of AultCare's Medical Case Management is managing the high cost of catastrophic illnesses while maintaining quality of care. Case management is used to describe a number of different approaches to planning, coordinating, providing and financing medical care. Case Management requires the simultaneous cooperation of AultCare, the Physician, the patient, and the patient's family. Telephonic follow up is provided to create and evaluate a goal oriented treatment plan. The focus of case management can include, but is not limited to, chronic disease states such as diabetes, COPD, or CHF, complex or catastrophic cases. Medical Case Management programs develop an individual plan designed to coordinate and mobilize health care resources to address specific medical problems and patient needs. The result should be a claim savings through effective medical management.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information and an extension of time to render our decision.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date of the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.
Copayments	**HMO Option**: A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician, you pay a copayment of $15 per office visit, and $20 per office visit for specialty care physicians. **HDHP Option**: There are no copayments in the HDHP.
Deductible	**HMO Option**: There is no deductible under the HMO. **HDHP Option**: A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. If you use PPO providers, the calendar year deductible is $2,000 per person. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $4,000. If you use non-PPO providers, your calendar year deductible increases to a maximum of $4,000 per person ($8,000 per family). Whether or not you use PPO providers, your calendar year deductible will not exceed $6,000 per person ($12,000 per family). Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan. And, if you change from Self and Family to Self-Only, or from Self-Only to Self and Family during the year, we will credit the amount of covered expenses already applied toward the deductible of your old enrollment to the deductible of your new enrollment. Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan. If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.
Coinsurance	**HMO Option**: There is no coinsurance under the HMO. **HDHP Option**: Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: You pay 20% of our allowance for a Preferred Provider Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived. For example, if your physician ordinarily charges $100 for a service but routinely waives your 20% coinsurance, the actual charge is $80. We will pay $64 (80% of the actual charge of $80).

Differences between our Plan allowance and the bill

In-network providers agree to limit what they will bill you. Because of that, when you use a network provider, your share of covered charges consists your copayments (**HMO Option** only) or your deductible and coinsurance (**HDHP Option** only).

HDHP Option: Here is an example about coinsurance: You see a network physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just – 20% of our $100 allowance ($20). Because of the agreement, your network physician will not bill you for the $50 difference between our allowance and his bill.

Out-of-network providers, on the other hand, have no agreement to limit what they will bill you. When you use an out-of-network provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and charges on the bill. Here is an example: You see an out-of-network physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 40% of our $100 allowance ($40). Plus, because there is no agreement between the out-of-network physician and us, he can bill you for the $50 difference between our allowance and his bill.

Your catastrophic protection out-of-pocket maximum

HMO Option: There is no catastrophic protection out of pocket maximum.

HDHP Option: There is a limit to the amount you must pay out-of-pocket for coinsurance for the year for certain charges. When you have reached this limit, you pay no coinsurance for covered services for the remainder of the calendar year. See Section 1. *FEHBFacts.*

PPO benefit: Your out-of-pocket maximum is $4,000 for a Self-Only and $8,000 for Self and Family enrollment if you are using PPO providers. Only eligible expenses for PPO providers count toward this limit.

Non-PPO benefit: Your out-of-pocket maximum is $8,000 for a Self-Only and $16,000 for a Self and Family enrollment if you are using Non-PPO providers. Eligible expenses for network providers also count toward this limit. Your eligible out-of-pocket expenses will not exceed this amount whether or not you use network providers.

Out-of-pocket expenses for the purposes of this benefit are:

• The 20% you pay for PPO Inpatient hospital charges, Surgical, Maternity and Diagnostic and treatment services

• The 40% you pay for non-PPO Inpatient hospital charges, Surgical, Maternity and Diagnostic and treatment services; and

The following cannot be included in the accumulation of out-of-pocket expenses:

• Expenses in excess of our allowance or maximum benefit limitations

• Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements.

• Expenses in excess of Plan maximums

Carryover	If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefit changes are effective January 1. Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit f your new option.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the governement facility directly for more information.

Section 5. Benefits

This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. *Make sure that you review the benefits that are available under the option in which you are enrolled.* To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-344-8858 or on our Website at www.aultcare.com.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• Plan physicians must provide or arrange your care.

• A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.

• Be sure to read Section 4. *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	$15 co pay per office visit for Primary Care Physicians $20 co pay per office visit for Specialty Care Physicians
At home	Nothing
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG • BRCA/BART testing	• Nothing if you receive these services during your office visit; otherwise • $15 co pay per office visit • BRCA/BART See pg.18 "You need prior Plan approval for certain services"
Preventive care, adult	**High Option**
Routine physical every year; which includes: Routine Screenings, such as: • Physicals • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 • Colonoscopy screening - every ten years starting at age 50	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Routine Prostate Specific Antigen (PSA) test - one annually for men age 50 and older	Nothing
Well Woman care, including but not limited to: • Routine OB/GYN including 1 Pap smear and related services • Human papillomavirus testing for women age 30 and up once every three years. • Annual counseling for sexually transmitted infections. • Annual counseling and screening for human immune-deficiency virus. • Contraceptive methods and counseling. • Screening and counseling for interpersonal and domestic violence.	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Hearing examinations and testing for ages 18 and over Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing Nothing
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: – Eye exams through age 17 to determine the need for vision correction, which include: – Hearing exams through age 17 to determine the need for hearing correction, which include: – Examinations done on the day of immunizations (up to age 22) Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing

Benefit Description	You pay
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	Nothing for prenatal care or the first postpartum care visit; $15 per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services. $150 co-pay per admission
Breastfeeding support, supplies and counseling for each birth	Nothing
Not covered	*All charges*
Family planning	**High Option**
Contraceptive counseling on an annual basis for women	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See *Surgical procedures* Section 5(b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral and injectable fertility drugs under the prescription drug benefit.	$15 per office visit for men; Nothing for women
Not covered: *• Reversal of voluntary surgical sterilization* *• Genetic counseling* *• Elective abortion*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs - *injectable and oral fertility drugs under Rx benefit*	$20 per office visit

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
Not covered: *• Assisted reproductive technology (ART) procedures, such as:* *– In vitro fertilization* *– Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections • Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 38. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We only cover GHT when we preauthorize the treatment. Call 1-800-344-8858 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$20 per office visit
Physical and occupational therapies	**High Option**
60 visits per year, per service for each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a provider: • orders the care Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided.	$20 per service, per each outpatient visit Nothing per visit during covered inpatient admission.

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	**High Option**
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	**High Option**
60 visits per year, per service of speech therapists.	$20 per office visit $20 per outpatient visit Nothing per visit during covered inpatient admission.
Habilitative Service	**High Option**
Children (0-21) yrs of age with a medical diagnosis of Autism Spectrum disorder. • Outpatient Physical Rehabilitation Services including - Speech and Language therapy and/or Occupational therapy, performed by a licensed therapist, 60 visits per year, per service - Applied Behavorial Analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan, 20 hours per week. - Mental/Behavioral Outpatient Services performed by a licensed Psychologist, Pyschiatrist, or Physician to provide consultation , assessment, development and oversight of treatment plans, 60 visits per year total.	$20 per office visit, per each outpatient visit Nothing per visit during covered inpatient admission.
Hearing services (testing, treatment, and supplies)	**High Option**
• Hearing testing for children through age 17, which include: hearing examinations, testing, and hearing aids for hearing loss (see *Preventive care, children*). • Hearing aids up to $1,000 per ear every 36 months for ages 18 and over. • When related to illness or injury, evaluation, diagnostic hearing tests (performed by an M.D., D.O., or audiologist), and treatment. • Routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children* External hearing aids, see Section 5(a) Orthopedic and prosthetic benefits. Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants; see Section 5(a) *Orthopedic and prosthetic devices.* For information on the professional charges for the surgery to insert BAHA or cochlear implants, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	$20 per office visit
Not covered: • *Hearing services that are not shown as covered, such as routine hearing tests for hearing loss as the result of aging*	*All charges*

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	**High Option**
In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (to provide a written lens prescription) may be obtained from Plan providers.	$20 per office visit
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$20 per office visit
• Eye exam to determine the need for vision correction for children and adults Coverage includes: • one complete refractory eye examination by a Plan provider every 24 months; and • one set of prescribed frames with a $55 maximum Plan payment; or • one set of single vision lenses with a $35 maximum Plan payment; or • one set of bi-focal lenses with a $55 maximum Plan payment; or • one set of tri-focal lenses with a $150 maximum Plan payment; or • one set of prescribed contact lenses with a $150 maximum Plan payment	$20 per office visit All charges over the maximum Plan payments.
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$20 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes; Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • External hearing aids and testing to fit them as shown in *Hearing Services* • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. - Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. *Note:* For information on the professional charges for the surgery to insert BAHA or cochlear implants, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services. • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy.	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High Option**
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Note: For information on the professional charges for the surgery to insert the implant, see Section 6(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 6(c) Services provided by a hospital or other facility, and ambulance services.	Nothing
Not covered: *• Orthopedic and corrective shoes, arch supports, foot orthotics unless more than supportive devices for the feet, heel pads and heel cups* *• Lumbosacral supports* *• Corsets, trusses, elastic stockings, support hose, and other supportive devices* *• Prosthetic replacements provided less than (5) years after the last one we covered*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheel Chairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps Note: Call us at 1-800-344-8858 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	Nothing
Not covered: Motorized wheelchairs	*All charges*
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: *• Nursing care requested by, or for the convenience of, the patient or the patient's family* *• Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*

Benefit Description	You pay
Chiropractic	**High Option**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$20 per office visit
Not covered: Maintenance care	*All charges*
Alternative treatments	**High Option**
No Benefit	All charges
Educational classes and programs	**High Option**
Coverage is provided for: • Tobacco Cessation programs, including: - individual, group and telephone counseling - prescription drugs approved by the FDA to treat tobacco dependence. (see Prescription drug benefits) • Childhood obesity education • Diabetes self management training	Nothing for counseling for up to two quit attempts per year with up to 4 tobacco cessation counseling sessions per quit attempt. Nothing

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• Plan physicians must provide or arrange your care.

• Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

• The services listed below are for the charges billed by a physician or other health care professional for your surgical care. ***See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).***

• **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) Eligible members must show each of the following criteria is present: – weighs 100 pounds over ideal weight OR has Body Mass Index of greater than 40, OR has Body Mass Index of greater than 35 and has a clinically serious condition (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, musculoskeletal dysfunction) – failure to lose significant weight or history of regaining weight despite compliance with nonsurgical programs – no specific correctable medical condition that would be the cause for obesity – must be age 18 or over – treatment provided by a surgical program experienced in bariatric surgeries using a multifisciplinary approach including medical, psychiatric, nutritional, exercise, psychological, and supportive consultations and counseling • Insertion of internal prosthetic devices. See Section 5(a) – *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing • Look in Section 5(c) for changes associated with the facility (i.e. hospital, surgical center, etc...)

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
Not covered: • *Reversal of voluntary sterilization* • Routine treatment of condition of the foot; see Foot care	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: – Surgery to produce a symmetrical appearance of breasts; – Treatment of any physical complications, such as lymphedemas; – Breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$20 per office visit; nothing for hospital visits
Not covered: *• Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* *• Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Removal of Partial and for fully bony impactions • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • TMJ treatment and services(non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures	$20 per office visit; nothing for hospital visits
Not covered: *• Oral implants and transplants* *• Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Benefit Description	You pay
Organ/tissue transplants	**High Option**
These **solid organ transplants** are subject to medical necessity and experimental/ investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestines - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent derm cell tumors (including testicular cancer) **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases respond to transplant. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic luekemia (CLL/SLL)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Mucolipidosis (e.g. Ganther's disease, metachromatic leukodystrophy, adrenoleukodystropy) - Mucopolysaccharidosis (e.g. Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux'-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic Hemophagocyte deficiency diseases (e.g. Wiskott-Aldrich symdrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced hodgkins lymphoma with recurrence (relapsed) - Advanced non-hodgkins lymphoma with recurrence (relapsed)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Acute myeloid leukemia - Advanced myeloproliferative disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Myelodysplasia/Myelodysplastic Syndromes - Parpxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autogolous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amloidosis - Neuroblastoma These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the plan's medical director in accordance with the plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on cost related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkins lymphoma - Advanced non-Hodgkins lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Myelodysplasia/Myelodysplastic Syndromes - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogenic, reduced intensity conditioning or (RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous leukemia) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MSDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants - Advanced Hodgkins lymphoma - Advanced non-Hodgkins lymphoma - Aggressive non-Hodgkin's lymphomas - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Breast Cancer - Chronic myelogenous lymphom - Childhood rhabdomyosarcoma - Childhood myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple sclerosis - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expense for the actual solid organ donor or up to four bone marrow stem cell transplant donors per year from individuals unrelated to the patient in addition to the testing of family members.	Nothing
Not covered:	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (Inpatient) • Hospital (Outpatient) • Skilled Nursing facility • Ambulatory surgical center • Office	Nothing

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.

• Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

• The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

• **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations; • General nursing care; • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semi-private room rate.	Copay of $150 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: *• Custodial care* *• Personal comfort items, such as telephone, television, barber services, guest meals and beds* *• Private nursing care, except when medically necessary* *• Non-covered facilities, such as nursing homes, schools*	*All charges*

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$50 copay
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care benefit: The Plan provides a comprehensive range of benefits, with no day or dollar limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor	Nothing
Not covered: • *Custodial care* • *Rest Cures* • *Domiciliary* • *Convalescent care*	*All charges*
Hospice care	**High Option**
• Supportive and palliative care • Inpatient and outpatient care • Family counseling Note: limited to life expectancy of six (6) months or less	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**High Option**
• Local professional ambulance service when medically appropriate	Nothing

Section 5(d). Emergency services/accidents

Important things to keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctor's services Note: We waive the ER copay if you are admitted to the hospital.	$50 copay
Not covered: *• Elective care or non-emergency care*	*All charges*

Benefit Description	You pay
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctor's services Note: We waive the ER copay if you are admitted to the hospital.	$50 copay
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing

Section 5(e). Mental health and substance abuse benefits

Important things to keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.

• Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

• **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the pre-authorization process and get Plan approval of your treatment plan: All out-of-network admissions, partial hospitalization programs and intensive out-patient programs require preauthorization. For preauthorization, call us at 1-800-344-8858.

• We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

• OPM will base it's review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 per office visit

Benefit Description	You pay
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	Nothing if you receive these services during your office visit; otherwise, $20 per office visit
• Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general ursing care, meals and special diets, and other hospital services	Nothing
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	Nothing
Not covered	**High Option**
• Services that are not part of a preauthorized approved treatment plan	All charges

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

• We cover prescribed drugs and medications, as described in the chart beginning on the next page.

• Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.

• Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.

• Be sure to read Section 4. *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a retail pharmacy. We pay a higher level of benefits when you use a network pharmacy.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary, a set or list of medications indicating a preferred status. If your physician believes a name brand drug is necessary, or there is no generic available, your physician may prescribe a name brand drug from the Plan's formulary list. The Plan's formulary does not exclude medications from coverage, but requires a higher copayment for non-formulary drugs. We have an open formulary. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-344-8858.
- **These are the dispensing limitations.** Prescriptions are filled up to a 34 day supply per copay. Maintenance drugs are dispensed up to a 90 day supply for one copay at mail order.
- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than a brand name drug. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs. You can save money by using generic drugs. However, you and your physician have the option to request a brand name if a generic option is available. Using the most cost-effective medication saves money. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **When you do have to file a claim.** When you do not use your prescription drug card.
- Certain drugs require prior authorization where your physician will submit a letter of medical necessity. For a list of these drugs, call Customer Service at 330-363-6360 or 1-800-344-8858.
- During a National emergency or call to active military duty requiring an extended supply of prescription drugs, call Customer Service at 330-363-6360 or 1-800-344-8858.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin: a copayment applies to each 34 day supply • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Section 3, prior approval) - Contraceptive drugs and devices - Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent, and acetone test tablets. - Intravenous fluids and medication for home use are covered under Medical and Surgical Benefits - Growth hormone • Fertility Drugs - Oral and injectable fertility drugs under Rx benefit *Note: Pharmacy Formulary can be found on the web at* www.aultcare.com *or call AultCare Customer Service at 330-363-6360 or 1-800-344-8858.*	**At Retail 1 – 34 day supply** **Tier I – Generic -** $20 copayment **Tier II – Preferred II -** $30 or 20% whichever is greater **Tier III – Preferred III -** $40 or 30% whichever is greater with a set RX limit of $200 **Tier IV – Non-Preferred IV -** $55 or 40% whichever is greater with a set RX limit of $200 **Tier V – Specialty -** $135 or 20% whichever is greater with a set per Rx limit of $200 (30 day supply only) **Mail Order 35 – 90 day supply** **Tier I – Generic I -** $55 copayment **Tier II – Preferred II -** $80 or 15% whichever is greater **Tier III – Preferred III -** $110 or 25% whichever is greater with a set RX limit of $200 **Tier IV – Non-Preferred IV -** $150 or 35% whichever is greater with a set RX limit of $200 **Tier V – Specialty -** $125 or 20% whichever is greater with a set RX limit of $200 (30 day supply only) Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Medications that are covered and recommended by the US Preventive Services Task Force include: • Lo-Dose Aspirin for adults • Folic Acid (Females only ages 16-55) • Ferrous Sulfate Drops (Children 6 months to 12 months) • Vitamin D OTC for adults age 65 and older, with a physician prescription	Nothing
Women's contraceptive drugs and devices Note: Over-the-counter contraceptives drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• Tobacco cessation drugs Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence requires a written prescription and are covered in-network only.	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Vitamin Supplements are not covered except as shown above, nutrients and food supplements even if a physician prescribes or administers them* • *Non-prescription medicines* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 10 Coordinating benefits with other coverage.

• Plan dentists must provide or arrange your care.

• We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 6 (c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

• Be sure to read Section 5, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 10 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	30% of allowable charges
Dental benefits	**High Option**
Preventive and Diagnostic • Oral Exam (one per year) • Prophylaxis or cleaning (one per year) • Annual application of fluoride up to age 12 • Sealants • X-rays, including bite wings (limited to once per year) and panoramic (limited to once every 5 years) • Vitality test • Oral cancer exam • Study Models • Emergency treatment, limited to the relief of pain, bleeding, swelling or life threatening conditions • Diagnostic services **Basic Restorative** • Restorative • Endodontics • Periodontics • Oral Surgery • Prosthodontics **Major Restorative** • Full and partial dentures • Fixed bridges • Crowns • Inlays • Onlays	30% of allowable charges

Dental benefits - continued on next page

Benefit Desription	You Pay
Dental benefits (cont.)	**High Option**
• replacement period for major service such as crowns/dentures/bridges every five years • replacement of congentially missing tooth	30% of allowable charges
Not covered: ***Implants and Related Services* ***Other dental services not shown as covered*	*All charges*

Section 5. High Deductible Health Plan Benefits

See page 15 for how our benefits changed this year and page 115 for the benefit summary.

Section 5. High Deductible Health Plan Overview

This plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the general exclusions in Section 6: they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 1-800-344-8858 or on our Website at www.aultcare.com**.**

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP option, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 67. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: in-network preventive care; traditional in-network health care that is subject to the deductible; savings, catastrophic protection for out-of-pocket expenses, and, health education resources and account management tools.

- **Preventive care** — The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are described in Section 5 *Preventive care. You do not have to meet the deductible before using these services.*

- **Traditional medical coverage** — After you have paid the Plan's deductible, we pay benefits under traditional in-network coverage described in Section 5. The Plan typically pays 80% for in-network and 60% for out-of-network care.

  Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance abuse benefits
  - Prescription drug benefits

- **Savings** — Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see for more details).

- **Health Savings Accounts (HSAs)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA and/or Indian Health Services (HIS) benefits within the last three months or do not have other health insurance coverage. In 2015, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $83.33 per month for a Self-Only enrollment or $166.66 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is an annual $3,350 for an individual and $6,650 for a Family. See maximum contribution information on page 60. You can use funds in your HSA to help pay your health plan deductible**.** You own your HSA; so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by Health Equity.
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e.: Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expenses.)
- Your unused HSA funds and interest accumulate from year to year
- It's portable – the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA (such as FSAFEDS offers-see Section 11), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in a HCFSA, we will establish an HRA for you.

- **Health Reimbursement Arrangements (HRA)**

If you aren't eligible for an HSA, for example you are enrolled in Medicare or have another health plan; we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2015, we will give you an HRA credit of $1,000 per year for a Self-Only enrollment and $2,000 for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by AultCare Health Plan.
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment

- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an *FSAFEDS* Health Care Flexible Spending Account (HCFSA). However, you must meet *FSAFEDS* eligibility requirements.

• **Catastrophic protection and cost transparency**	An annual deductible of $2,000 self and $4,000 self and family is applied before any plan benefits are paid. Benefit payments for non-network provider services are based on usual, customary, and reasonable criteria. The deductible and coinsurance are subject to out-of-pocket maximums of $4,000 self/$8,000 self and family in-network and $8,000 self/ $16,000 self and family out-of-network.
• **Catastrophic protection for out-of-pocket expenses**	When you use network providers, your annual maximum for out-of-pocket expenses (deductibles and coinsurance) for covered services is limited to $4,000 per person or $8,000 per family enrollment. When you use out-of-network providers, your annual maximum for out-of-pocket expenses (deductibles and coinsurance) for covered services is limited to $8,000 per person or $16,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum*, Section 5 *Traditional medical coverage subject to the deductible* for more details.
• **Health education resources and account management tools**	HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with **Health Equity**, this HDHP's custodian as defined by Federal tax code and approved by IRS. *Note: Please contact Health Equity to Open up an Account and notify AultCare afterwards. See Eligibility section for more information.* ***Health Equity*** ***HealthEquity, Inc.*** ***15 W. Scenic Pointe Dr., Ste. 400*** ***Draper, UT 84020*** ***Phone 877.694.3942*** *or* www.healthequity.com	***AultCare Health Plan*** is the HRA fiduciary for this Plan. ***AultCare*** ***2600 Sixth Street SW P.O. Box 6910*** ***Canton, OH44706*** ***1-800-344-8858 or www.aultcare.com***
Fees	Set-up fee is paid by the HDHP. No additional cost to the member.	***AultCare Health Plan*** None.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term case coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA and/or Indian Health Services (HIS) benefits in the last three months • Complete and return all banking paperwork.	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of our monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Espress, MyPay, etc.)	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for the length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.

• **Self Only enrollment**	For 2015, a monthly premium pass through of $83.33 will be made by the HDHP directly into your HSA each month.	For 2015, your HRA annual credit is $1,000 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2015, a monthly premium pass through of $166.66 will be made by the HDHP directly into your HSA each month.	For 2015, your HRA annual credit is $2,000 (proratedfor mid-year enrollment).
• **Contributions/ credits**	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,350 for an individual or $6,650 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were inelgibile to contribut to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 63.	The full HRA credit will be available, subject, to proration, on the effective date of enrollment. The HRA does not earn interest.
• **Self-Only enrollment**	You may make an annual maximum contribution of $2,350.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of $4,650.	You cannot contribute to the HRA.
• **Access funds**	You can access your HSA by the following methods:	

	Debit card Withdrawal form Checks	For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through AultCare Health Plan. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.
• **Distributions/ withdrawals** - **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered through the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimburseable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change) • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA • The fiduciary sends out HSA paperwork for the enrollee to complete and the fiduciary receives the completed paperwork.	The HRA credit will be available, subject to proration, on the effective date of enrollment.
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.

	If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 58 for HSA eligibility.	If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If You Have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax dedcution when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective data is after January 1st or you otherwise have partial year coverage, you are eligibile to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die**

  If you have not named a beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, **physician prescribed** over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although **physician prescribed** over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

  You will receive a periodic statement that shows the "premium pass through", withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount.

If You Have an HRA

- **Why an HRA is established**

  If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

  Please review the chart on page 60 which details the differences between an HRA and an HSA. The major differences are:

  • you cannot make contributions to an HRA

  • funds are forfeited if you leave the HDHP

  • an HRA does not earn interest,

  • HRAs can only pay for qualified medical expenses, such as deductibles, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

• Preventive care services listed in this Section are not subject to the deductible.

• You must use providers that are part of our network.

• For all other covered expenses, please see Section 5 - *Traditional medical coverage subject to the deductible.*

Benefit Description	You pay
Preventive care, adult	**High Option**
Routine screenings, such as: • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test - one annually for men age 50 and older • Colorectal Cancer Screening, including: - Fecal occult blood test yearly starting at age 50 - Sigmoidoscopy screening - every five years starting at age 50 - Colonoscopy screening - every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older	In network: Nothing Out-of-network: 50% of the plan allowance and any difference between our allowance and the billed amount
Well women care; including, but not limited to: • Routine OB/GYN exam including 1 Pap smear and related services • Human papillomavirus testing for women age 30 and up to once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	In network: Nothing Out-of-network: 50% of the plan allowance and any difference between our allowance and the billed amount
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	In network: Nothing Out-of-network: 50% of the plan allowance and any difference between our allowance and the billed amount
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.	
Routine annual physicals and Routine exams • One routine OB/GYN exam including 1 Pap smear and related services • routine eye exam (see Vision services pg. 72) • routine hearing exam (see Hearing services pg. 72)	In-network: Nothing Out-of-network: 50% of any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Not covered: *• Physical exams required for obtaining or continuing employment or insurance, or travel* *• Immunizations, boosters, and medications for travel*	*All charges*
Preventive care, children	**High Option**
• Professional services, such as: - Well-child care charges for routine examinations, immunizations and care (up to age 22) - Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: - Eye exam through age 17 to determine the need for vision correction - Hearing services through age 17 to determine the need for hearing correction (See *Hearing services*)	In-network: Nothing Out-of-network: 50% of any difference between our allowance and the billed amount
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.	
Not covered: *• Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* *• Immunizations, boosters, and medications for travel.*	*All charges*

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• In-network preventive care is covered at 100% of plan allowance under Section 5(a) and is not subject to the calendar year deductible.

• The deductible is $2,000 per person or $4,000 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in Section 5.

• You must pay your deductible before your Traditional Medical Coverage may begin.

• Under Traditional Medical Coverage, you are responsible for your coinsurance for covered expenses.

• When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance and deductibles total $4,000 per person or $8,000 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance). Please refer to Section 3. *How you get care.*

• In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply unless an approved referral is obtained.

• Be sure to read Section 4. *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage.

Benefit Description	You pay After the calendar year deductible…
Deductible before Traditional medical coverage begins	**High Option**
The deductible applies to almost all benefits in this Section. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of $2,000 per person or $4,000 per family enrollment
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance from your HSA or HRA, or you can pay for them out-of-pocket Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• The in-network deductible is $2,000 Self-Only or $4,000 per Self and Family enrollment each calendar year. The out-of-network deductible is $4,000 Self-Only or $8,000 per Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.

• After you have satisfied your deductible, coverage begins for Traditional medical services.

• Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.

• Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage.

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • Office medical consultations •Second surgical opinion	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG • BRCA/BART testing	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount. BRCA/BART See pg.18 "You need prior Plan approval for certain services"

Benefit Description	You pay After the calendar year deductible…
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care (see *Section 5(a) Preventive care*) • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: Prenatal care is covered under *Preventive Care* (not subject to the deductible)
Breastfeeding support, supplies and counseling for each birth	
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (see *Surgical procedures* Section 5) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral and injectable fertlity drugs under the prescription drug benefit.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • Reversal of voluntary surgical sterilization. • Genetic counseling • Elective abortion	*All charges*

Benefit Description	You pay After the calendar year deductible…
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) • Fertility drugs - injectable and oral fertility drugs under Rx benefit	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: *• Assisted reproductive technology (ART) procedures, such as:* *– In vitro fertilization* *– Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* *• Services and supplies related to ART procedures* *• Cost of donor sperm* *• Cost of donor egg*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Allergy serum	In-network: Nothing Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 77. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We only cover GHT when we preauthorize the treatment. Call 330-363-6360 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies	**High Option**
60 visits per year, per service of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy to when a provider: • Orders the care Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: *• Long-term rehabilitative therapy* *• Exercise programs*	*All charges*
Speech therapy	**High Option**
60 visits per year, per service of speech therapists.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Habilitative Service	**High Option**
Children (0-21) yrs of age with a medical diagnosis of Autism Spectrum disorder. • Outpatient Physical Rehabilitation Services including - Speech and Language therapy and/or Occupational therapy, performed by a licensed therapist, 60 visits per year, per service - Applied Behavorial Analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan, 20 hours per week. - Mental/Behavioral Outpatient Services performed by a licensed Psychologist, Pyschiatrist, or Physician to provide consultation , assessment, development and oversight of treatment plans, 60 visits per year total.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount.
Hearing services (testing, treatment, and supplies)	**High Option**
• Hearing exams for children through age 17, which include: hearing examinations, testing, and hearing aids for hearing loss (see *Preventive routine care, children)* • Hearing aids up to $1,000 per ear every 36 months for ages 18 and over • When related to illness or injury, evaluation, diagnostic hearing tests (performed by an M.D., D.O., or audiologist), and treatment. • External hearing aids, see Section 5(a) Orthopedic and prosthetic benefits.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants; see Section 5(a) *Orthopedic and prosthetic devices.* For information on the professional charges for the surgery to insert BAHA or cochlear implants, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Hearing services that are not shown as covered, such as routine hearing tests for hearing loss as the result of aging*	All charges
Vision services (testing, treatment, and supplies)	**High Option**
• Eye exam to determine the need for vision correction for children through age 17 Note: See *Preventive care, children* for eye exams for children.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: *• Eye exercises and orthoptics* *• Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes; Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Hearing aids and testing to fit them as shown in *Hearing Services* • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	**High Option**
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: *• Orthotics unless more than supportive devices for the feet* *• Arch supports* *• Heel pads and heel cups* *• Lumbosacral supports* *• Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Speech generating devices; • Blood glucose monitors; • Insulin pumps. Note: Call us at 1-800-344-8858 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Motorized wheelchairs	*All charges*
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include oxygen therapy, intravenous therapy and medications.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered:	*All charges*

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Home health services (cont.)	**High Option**
• Nursing care requested by, or for the convenience of, the patient or the patient's family; *• Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	**High Option**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Maintenance care	*All charges*
Alternative treatments	**High Option**
No Benefit	All charges
Educational classes and programs	**High Option**
Coverage is provided for: • Tobacco Cessation programs, including: - individual, group and telephon counseling - prescription drugs approved by the FDA to treat tobacco dependence. (see Prescription drug benefits) • Childhood obesity education • Diabetes self management training	Nothing for counseling for up to 2 quit attempts per year with up to 4 tobacco cessation counseling sessions per quit attempt. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• Plan physicians must provide or arrange your care.

• The in-network deductible is $2,000 Self-Only or $4,000 per Self and Family enrollment each calendar year. The out-of-network deductible is $4,000 Self-Only or $8,000 per Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section unless we indicate differently.

• After you have satisfied your deductible, coverage begins for Traditional medical services.

• Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.

• The services listed below are for the charges billed by a physician or other health care professional for your surgical care. ***See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)***

• **YOUR OUT-OF-NETWORK PHYSICIAN MUST GET PRECERTIFICATION.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Treatment of morbid obesity (bariatric surgery) Eligible members must show each of the following criteria is present: – weighs 100 pounds over ideal weight OR has Body Mass Index of greater than 40, OR has Body Mass Index of greater than 35 and has a clinically serious condition (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, musculoskeletal dysfunction) – failure to lose significant weight or history of regaining weight despite compliance with nonsurgical programs – no specific correctable medical condition that would be the cause for obesity – must be age 18 or over – treatment provided by a surgical program experienced in bariatric surgeries using a multifisciplinary approach including medical, psychiatric, nutritional, exercise, psychological, and supportive consultations and counseling	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**High Option**
• Insertion of internal prosthetic devices. See Section 5(a) – *Orthopedicandprosthetic devices* for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Reversal of voluntary sterilization	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Example of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed finger and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance of breasts; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: *• Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* *• Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • TMJ treatment and services (non dental); and • Other surgical procedures that do not involve the teeth or their supporting structures.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered:	*All charges*

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery (cont.)	**High Option**
• Oral implants and transplants *• Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the plan. Refer to Other services in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the plan. Refer to *other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diasnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extention of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases respond to transplant. • Allogeneic transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced myeloproliferative disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromaticleukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, and maroteaux-lamy syndrome variance) - Myelodysplasia Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott/Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiplemyeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
Mini- transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnoses listed below are subect to medical necessity review by the Plan. Refer to *other services* in Section 3 for prior authorization procedures. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced myeloproliferative disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow faliure and related disorders (i.e., Fanconi's PNH, pure red cell Aplasia) - Paraoxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or non lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plans medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitilazation related to treating the patients condition) if it is not provided by the clinical trial. Section 9 has additional information on cost related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. - Allogeneic transplants for • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Beta Thalassemia Major • Chronic inflammatory demyelination polyneuropathy (CDIP)	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
• Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Sickle cell anemia - Mini-transplants (non-myeloblative allogenic, reduced intensity conditioning or RIC) for • Acute lymphocytic or non-lymphocytic (ie., myelogenous)leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast Cancer • Chronic lymphocytic leukemia • Chronic myelogenous leumekia • Colon Cancer • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders (MDDs) • Myelodysplasia/Myelodysplastic Syndromes • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia - Autogolous Transplants • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Aggressive non-Hodgkin lymphomas • Breast Cancer • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
• Early stage (indolent or non advanced) small cell lymphocytic lymphoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin lymphoma) • Multiple sclerosis • Small cell lung cancer • Systemic lupus erythematosus • Systemic sclerosis - National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expense for the actual solid organ donor or up to four bone marrow stem cell transplant donors in addition to the testing of family members. Not covered: • Donor screening tests and donor search expenses except as shown above • Implants of artificial organs • Transplants not listed as covered	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) Professional services provided in - • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.

• The in-network deductible is $2,000 Self-Only enrollment and $4,000 per Self and Family enrollment each calendar year. The out-of-network deductible is $4,000 Self-Only enrollment and $8,000 per Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.

• After you have satisfied your deductible, your Traditional medical coverage begins.

• Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.

• Be sure to read Section 4. *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

• The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Sections 5(a) or (b).

• **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR OUT-OF-NETWORK INPATIENT ADMISSIONS, SKILLED NURSING FACILITIES AND HOME HEALTH CARE; FAILURE TO DO SO MAY RESULT IN A MINIMUM PENALTY UP TO $500.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	**High Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations; • General nursing care; • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. • Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered:	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	**High Option**
• *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicine • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Blood and blood derivatives not replaced by the member	All charges
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care benefit: The Plan provides a comprehensive range of benefits, with no day or dollar limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care* • *Rest Cures* • *Domiciliary* • *Convalescent care*	*All charges*
Hospice care	**High Option**
• Supportive and palliative care • Inpatient and outpatient care • Family counseling Note: limited to life expectancy of six (6) months or less	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Independent nursing, homemaker services	*All charges*

Benefit Description	You Pay After the calendar year deductible...
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	20% of the Plan allowance and any difference between our allowance and the billed amount

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• The in-network deductible is $2,000 Self-Only enrollment and $4,000 per Self and Family enrollment each calendar year. The out-of network deductible is $4,000 Self-Only enrollment and $8,000 per Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.

• After you have satisfied your deductible, your Traditional medical coverage begins.

• Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.

• Be sure to read Section 4. *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this plan, any follow-up care recommended by Out-of Network Providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay After the calendar year deductible…
Emergency within or outside our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctor's services	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All charges*
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	20% of the Plan allowance and any difference between our allowance and the billed amount

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this section. We added "(No deductible)" to show when a deductible does not apply.

• Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

• **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan: All out-of-network admissions, partial hospitalization programs and intensive out-patient programs require preauthorization. For preauthorization, call us at 1-800-344-8858.

• We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

• OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…
Professional services	**High Option**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, or clinical social workers.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible…
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered	**High Option**
Services that are not part of a preauthorized approved treatment plan	All charges

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications as described on the next page.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The in-network deductible is $2,000 Self-Only enrollment and $4,000 per Self and Family enrollment each calendar year. The out-of-network deductible is $4,000 Self-Only enrollment and $8,000 per Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- Be sure to read Section 4. Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescripton.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy or out-of-network pharmacy. We pay a higher level of benefits when you use a network pharmacy.
- **These are the dispensing limitations.** Prescriptions are filled up to a 34 day supply per copay. Maintenance drugs are dispensed up to a 90 day supply for one copay at mail order.

You pay 100% of the discounted amount at network pharmacies when you use your Prescription Identification card. Your claims are submitted to AultCare electronically and will be reimbursed at 80% after your in-network deductible is met. When purchasing prescriptions at an out-of-network pharmacy, you will not receive the discount. It will be necessary for you to submit those prescriptions to AultCare for reimbursement at 80% after your in-network deductible is met.

- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than a brand name drug. The U.S. Food and Drug Administration set quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs. You can save money by using generic drugs. However, you and your physician have the option to request a brand name if a generic option is available. Using the most cost-effective medication saves money. A generic eqivalent will be dispensed if it s available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **When you do have to file a claim.** When you do not use your prescription drug card.
- Certain drugs require prior authorization where your physician will submit a letter of medical necessity. For a list of these drugs, call Customer Service at 330-363-6360 or 1-800-344-8858.
- During a National emergency or call to active military duty requiring an extended supply of prescription drugs call Customer Service at 330-363-6360 or 1-800-344-8858.

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy. • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin; a copayment applies to each 34 day supply • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Section 3, prior approval) - Contraceptive drugs and devices - Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent, and acetone test tables. - Intravenous fluids and medication for home use are covered under Medical and Surgical Benefits - Growth hormone • Fertility Drugs Note: Pharmacy Formulary can be found on the web at www.aultcare.com or call AultCare Customer Service at 330-363-6360 or 1-800-344-8858	Using Prescription card: 20% of discounted amount. Not using Prescription drug card: 20% of plan allowance. No applicable discount
Medications that are covered and recommended by the US Preventive Services Task Force include: • Lo-Dose Aspirin for adults • Folic Acid (Females only ages 16-55) • Ferrous Sulfate Drops (Children 6 months to 12 months) • Vitamin D OTC for adults age 65 and older, with a physician prescription	Nothing
Women's contraceptive drugs and devices Note: Over-the-counter contraceptives drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing
• Tobacco cessation drugs Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence requires a written prescription and are covered in-network only.	In-network: Nothing Out-of-network: All Charges
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Vitamin Supplements are not covered except as shown above, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	In-network: 20% of the Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Dental benefits	**High Option**
We cover no other dental benefits.	All charges

Section 5(h). Special features

Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative benefit. If we identify a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
I Can Cope	Weekly cancer education sessions are presented by doctors, nurses and other professionals. The sessions are held by the Aultman Cancer Center and co-sponsored by the American Cancer Society. For information/registration, you may call 330-438-6290 or go online at http://www.cancer.org/treatment/supportprogramsservices/onlinecommunities/participateinacancereducationclass/icancopeonline/index. Free parking is available.
Common Ground	A cancer support group for cancer patients and their caregivers. It's led by an Aultman oncology social worker. For information, call 330-438-6290. Free parking is available.
Woman-to-Woman Cancer Support Group	The Woman-to-Woman Cancer Support Group meets the second and fourth Thursday of each month at 6:30 PM in the Aultman Hospital Physician Center. The Woman-to-Woman Cancer Support Group is open to woman of all ages who are battling cancer. The shared experiences of a cancer journey bond women together quickly, and the group provides a "safe" place to talk about fear, guilt, pain and depression. Currently, approximately 20 women meet twice a month for the Woman-to-Woman Support Group. For information please contact Aultman Cancer Center at 330-363-6891.
Grief Services Support Groups	Group meetings are offered for children, teens and adults who are coping with the loss of a loved one. Led by expert grief facilitators, these sessions are held at the Compassionate Care Center on the Aultman Woodlawn campus located at 2821 Woodlawn Avenue in Canton. Call Beth Wengerd at 330-479-4835 for more information and to register.
AultLine	For any of your health concerns, 24 hours a day, 7 days a week, you may call 330-363-7620 or 1-866-422-9603 and talk with a registered nurse who will discuss treatment options and answer your health questions.

Section 5(i). Health education resources and account management tools

Special features	Description
Health education resources	The Aultman Institute publishes a newsletter to keep you informed on a variety of issues related to your good health. Visit our Website at www.aultcare.com Visit this Website www.aultman.org for information on: General health topics Links to health care news Cancer and other specific diseases Drugs/medication interactions Kids' health Patient safety information Several helpful web site links.
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through www.aultcare.com. Your balance will also be shown on your explanation of benefits (EOB) form. You will receive an EOB after every claim. If you have an **HSA:** • You will receive a monthly bank statement from Health Equity outlining your account balance and activity for the month. • You may also access your account on-line at **www.healthequity.com** If you have an **HRA:** • Your HRA balance will be available online through www.aultcare.com Your balance will also be shown on your EOB form.
Consumer choice information	As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.aultcare.com Link to online pharmacy through www.aultcare.com
Care support	Patient safety information is available online at www.aultcare.com **Case Management:** The goal of AultCare's Medical Case Management is managing the high cost of catastrophic illnesses while maintaining quality of care. Case management is used to describe a number of different approaches to planning, coordinating, providing and financing medical care. Case Management requires the simultaneous cooperation of AultCare, the Physician, the patient, and the patient's family. Telephonic follow up is provided to create and evaluate a goal oriented treatment plan. The focus of case management can include, but is not limited to, chronic disease states such as diabetes, COPD, or CHF, complex or catastrophic cases. Medical Case Management programs develop an individual plan designed to coordinate and mobilize health care resources to address specific medical problems and patient needs. The result should be a claim savings through effective medical management.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of AultCare, and all appeals must follow their guidelines. For additional information contact AultCare at 1-800-344-8858 or visit their website at www.aultcare.com.

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**.

AultWorks Occupational Medicine

AultWorks is an occupational medicine program that provides comprehensive medical care to employees. AultWork's occupational health physicians and staff are trained in preventing and treating injuries and/or illnesses resulting from exposure to physical, chemical or biological hazards in the workplace.

Aultman Weight Management

Aultman has designed 3 approaches to weight loss, each supervised by a team of healthcare professionals, plus individual and group support. Each participant receives a screening to determine which of the three programs will be most effective. The team may also suggest a blend of elements from each of the programs. Participants continue through reducing, adapting and sustaining phases for lifelong weight control. All programs include FREE membership in Aultman's four Fitness centers.

AultCare Individual

AultCare Individual health plans are perfect for recent high school and college graduates, Self Employed Individuals, Early Retirees, Individuals looking for short term coverage and Part time employees. This will be perfect for the dependents beyond age 26.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Extra care costs and research costs associated with clinical trials.

Section 7. Filing a claim for covered services

There are four types of claims. Three of the four types-Urgent care claims, Pre-service claims, and Concurrent review claims-usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type-Post-service claims-is the claim for payment of benefits after services or supplies have been received.

This Section primarily deals with post-service (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval) including urgent care claims procedures.

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers.Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility must file on the UB-04 form. For claims questions and assistance, contact us at 1-800-344-8858 or at our Website at www.aultcare.com.

When you must file a claim – such as for services you received outside of the Plan's service area– submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

• Covered member's name, date of birth, address, phone number and ID number;

• Name and address of the physician or facility that provided the service or supply;

• Dates you received the services or supplies;

• Diagnosis;

• Type of each service or supply;

• The charge for each service or supply;

• A copy of the explanation of benefits, payments, or denial from any primary payor-such as the Medicare Summary Notice (MSN);

• Receipts, if you paid for your services. Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Note: Canceled checks, cash register receipts, or balance due statments are not acceptable substitutes for itemized bills.

Submit your claims to:

AultCare Health Plan
2600 Sixth Street SW
Canton, Ohio 44710
1-800-344-8858

Records

Keep a separate record of the medical expenses of each covered family member. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service Department at 1-800-344-8858. Urgent care claims must meet the definition found in Section 11 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information to allow us to, we will inform you or your authozied representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) the end of the time frame, whichever is earlier.

We may provide our decisions orally within these time frames, but we will follow up with a written or electronic notification within three days of oral notification.

Concurrent care claims procedures

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our preapproved course of treatment as an appealable decision. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decsion within 24 hours after we receive the claim.

Pre-service claims for procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day. Our notice will include the circumstances underlying the request for the extention and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within 5 days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Post-service claims procedures

We will notify you within 30 days after we receive the claim. If matters beyond our control require an extention of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extention because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorize representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOB's and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determincation or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies - including a request for preauthorization/prior approval required by Section 3. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit www.aultcare.com. Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing AultCare Health Plan, 2600 Sixth Street SW, Canton, Ohio 44710 or calling 1-800-344-8858.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our intial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: AultCare Health Plan, 2600 Sixth Street SW, Canton, Ohio 44710; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

• 90 days after the date of our letter upholding our initial decision; or

• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or

• 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;

• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;

• Copies of all letters you sent to us about the claim;

• Copies of all letters we sent to you about the claim; and

• Your daytime phone number and the best time to call.

• Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition, may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim requested and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanenet loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-800-344-8858. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age;
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-800-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure.

For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouses group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stopped working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advanatage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is secondary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-344-8858 or see our Website at www.aultcare.com.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

We do not waive any costs if the Original Medicare Plan is your primary payor.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. • Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy. • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are generally covered by the clinical trials. These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 23.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 23.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Services we provide benefits for, as described in this brochure.
Custodial Care	Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of oral medications
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 23.
Experimental or investigational service	The Plan's Utilization Management team gathers information from various sources before making an independent evaluation to determine medical appropriateness and/or the experimental/investigational nature of new technology, i.e., the application of existing technology or new medical procedures, drugs, or devices. The Plan's decision is made in good faith, following a detailed factual background investigation of the claim and proposed service and interpretation of the Plan provisions. Sources the Plan may use include the Federal Drug Administration, Medicare guidelines, published scientific articles, and related medical society guidelines. If the plan decides that a service or supply is not medically appropriate and/or is experimental/investigational, that service or supply will not be eligible.
Group health coverage	Coverage provided by the Company for the Plan participant and dependants, if applicable.

Health care professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity A service or supply given by a Provider that is required to diagnose or treat your condition, illness or injury and which we determine is:

• Appropriate with regard to standards of good medical practice;

• Not solely for the convenience of you or a provider;

• The most appropriate supply or level or service which can be safely provided to you. When applied to the care of an Inpatient, this means that the services cannot be safely provided to you as an Outpatient.

Plan allowance Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obatin precertification, prior approval, or a referral results in a reduction of benefits.

Us/We Us and We refer to AultCare Health Plan

You You refers to the enrollee and each covered family member.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waing for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-344-8858. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** –Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents, including adult children (throught the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year) or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Reviw your FEDVIP dental plan's brochure for information on this benefit.**
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses, and frames or contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337, (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program -*FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility, or in an adult day care. To qualifiy for coverage under the FLTCIP, you must supply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information call, 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557), or visit www.ltcfeds.com.

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Summary of benefits for the HMO AultCare Health Plan- 2015

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• **Diagnostic and treatment services provided in the office**	$15 per office visit	29
Vision care:		
One exam every two years	$20 per office visit	34
Eyewear	Various payments	34
Services provided by a hospital:		
• **Inpatient**	$150 copay per admission	44
• **Outpatient**	$50 copay	45
Emergency benefits:		
• **In-area**	$50 copay but waived if admitted	46
• **Out-of-area**	$50 copay but waived if admitted	47
Mental health and substance abuse treatment:	Regular cost-sharing	48
Prescription drugs:	Retail Copay 1-34 day supply/Mail Order Copay 35-90 day supply. Speciality 30 day supply only.	
• Tier 1 Generic	$20 copayment at retail $55 copayment at mail order	51
• Tier 2 Preferred	$30 or 20% whichever is greater copayment at retail $80 or 15% whichever is greater copayment at mail order	51
• Tier 3 Preferred	$40 or 30% whichever is greater with a set RX limit of $200 copayment at retail $110 or 25% whichever is greater with a set RX limit of $200 copayment at mail order	51
• Tier 4 Non-Preferred	$55 or 40% whichever is greater with a set RX limit of $200 copayment at retail $150 or 35% whichever is greater with a set RX limit of $200 copayment at mail order	51

High Option Benefits	You pay	Page
• Tier 5 Speciality	$135 or 20% whichever is greater with a set RX limit of $200 copayment at retail (30 day supply only) $125 or 20% whichever is greater with a set RX limit of $200 copayment at mail order (30 day supply only) Note: both have 30 day supply only.	51
Dental care:		
Accidental injury benefit	Nothing	53
Preventive dental care	30%	53
Special features: Flexible benefit options, I Can Cope, Common Ground, Women-to-Women Cancer Support Group, Grief Services Support Groups and AultLine.		94

Summary of benefits for the HDHP AultCare Health Plan-2015

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

In 2015, for each month you are eligible for the Health Savings Account (HSA), AultCare will deposit $83.33 per month for Self-Only enrollment or $166.66 per month for Self and Family enrollment to your HSA. For the HSA, you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $2,000 for Self-Only and $4,000 for Self and Family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $1,000 for Self-Only and $2,000 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Under this Plan, most traditional medical care (other than some preventive care) is subject to a deductible. After you meet the deductible, you pay the indicated coinsurance up to the annual catastrophic protection maximum for out-of-pocket expenses. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network provider.

HDHP Benefits	You Pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	In-network: Nothing after $4,000/Self-Only or $8,000/Family enrollment per year. Out-of-network: $8,000/Self-Only or $16,000/ Family enrolment per year. Some costs do not count toward this protection	59
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	In-network: 20% of plan allowance Out-of-network: 40% of our allowance plus amount over our allowance.	69
Services provided by a hospital:		
• Inpatient	In-network:20% of plan allowance Out-of-network: 40% of our allowance plus amount over our allowance.	83
• Outpatient	In-network:20% of plan allowance Out-of-network: 40% of our allowance plus amount over our allowance.	84
Emergency benefits:		
• In-area • Out -of-area	In-network: 20% of plan allowance Out-of-network: 40% of our allowance plus amount over our allowance.	86, 87
Mental health and substance abuse treatment:	Regular cost-sharing	88
Prescription drugs:	20% of plan allowance	90
Special features:		94

	Flexible benefit options, I Can Cope, Common Ground, Woman-to-Woman Cancer Support Group, Grief Services Support Groups and AultLine.	

2015 Rate Information for AultCare Health Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to Postal Services employees. They are shown in special Guides plublished for APWU (including Material Distribution Center and Operating Services) NALC, NPMHU and NRLCA Career Postal Employees (see RI-70-2A); Information Technology/Accounting Services employees (see RI 70-2IT); Nurses (see RI 70-2N); Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees and Postal Career Executive Service employees (see RI 70-2IN); and non-career employees (see RI 70-8PS).

Postal Category 1 rates apply to career employees who are members of the APWU, NALC, NPMHU bargaining units.

PostalCategory 2 ratesapply to non-bargaining unit, non-executive, non-law enforcement employees, and non-law enforcement Inspection Service and Forensics employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, option 5

TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable Guide to Federal Benefits.

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	3A1	$202.01	$73.29	$437.69	$158.79	$59.26	$73.29
High Option Self and Family	3A2	$448.57	$227.28	$971.90	$492.44	$196.13	$227.28
HDHP Option Self Only	3A4	$123.27	$41.09	$267.08	$89.03	$32.46	$41.09
HDHP Option Self and Family	3A5	$248.87	$82.96	$539.23	$179.74	$65.54	$82.96