

AultCare Health Plan

www.aultcare.com

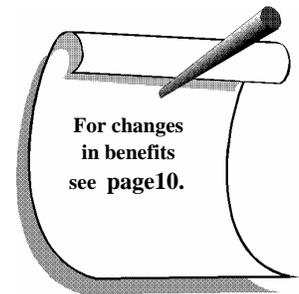
AULTCARE

2006

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

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

**Enrollment in this plan is limited. You must live or work in our
Geographic service area to enroll. See page 9 for requirements.**



Enrollment codes for this Plan:

3A1 High Option– Self Only

3A2 High Option – Self and Family

3A4 HDHP Option – Self Only

3A5 HDHP Option – Self and Family



Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-699

Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the Government Accountability Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

Important Notice from the AultCare Health Plan Our Prescription Drug Coverage and Medicare

OPM has determined that the AultCare Health Plan Prescription Drug Coverage, on average, comparable to Medicare Part D prescription drug coverage; this means you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. 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 the AultCare Health Plan will coordinate benefits with Medicare.

Remember: if you are an annuitant and you terminate your FEHB coverage, you may not enroll in the FEHB program.

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D, at a later date your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period 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 users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of AultCare Health Plan under our contract (CS2723) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the 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, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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 first.

Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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:

Be wary of giving 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.

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 1-800-344-8858 and explain the situation.
- If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

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); or
- Your child over age 22 (unless he/she is disabled and incapable of self support).

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.

You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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 that you take, including non-prescription (over-the-counter medicines).
- Tell them about any drug allergies you have.
- 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.

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 are 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 reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- ▶ www.ahrq.gov/consumer/pathqpack.html. 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/consumer.html. 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.
- ▶ www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this plan

This AultCare Health 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.

The High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component is a health plan product that provides traditional health care coverage and a tax advantaged way to help you build savings for future medical needs. An HDHP with an HSA or HRA is designed to give greater flexibility and discretion over how you use your health care benefits. As an informed consumer, you decide how to utilize your plan coverage with a high deductible and out-of-pocket expenses limited by catastrophic protection. And you decided how to spend the dollars in your HSA or HRA. You may consider:

- Using the most cost effective provider
- Actively pursuing a healthier lifestyle and utilizing your preventive care benefit
- Becoming an informed health care consumer so you can be more involved in the treatment of any medical condition or chronic illness.

The type and extent of covered services, and the amount we allow, may be different from other plans. Read our brochure carefully to understand the benefits and features of this HDHP. Internal Revenue Service (IRS) rules govern the administration of all HDHPs. The IRS Website at <http://www.ustreas.gov/offices/public-affairs/hsa/faq1.html> has additional information about HDHPs.

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.

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Annual deductible

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

Health Savings Account (HSA)

Health Saving 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 eligible for Medicare, 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 10% 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. In addition, 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

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles, coinsurance and copayments, are limited to \$4,000 for Self-Only enrollment, or \$8,000 for 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 Web site, www.opm.gov/insure. 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 there 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.

Your Rights

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

Years in existence

Profit status

If you want more information about us, call 1-800-344-8858, or write to AultCare Health Plan. You may also contact us by fax at 330-580-5527 or visit our Web site at www.aultcare.com.

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 Web site, www.opm.gov/insure. 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.

Service Area

To enroll in this Plan, you must live or work in our Service Area(s). This is where our network providers practice. Our Service Areas are:

- Stark
- Carroll
- Holmes
- Tuscarawas
- Wayne Counties in Ohio
- Canton metropolitan area in Ohio

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 How we change for 2006

Do not rely on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5.1 and 5.2 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 High Option only

- Your share of the non-Postal premium will increase by 9.5% for Self Only or 19.3% for Self and Family.

Changes to High Deductible Health Plan

- There are no changes.

Section 3 How you get care

Identification cards	<p>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.</p>
	<p>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 Web site: www.aultcare.com.</p>
Where you get covered care	<p>HMO Option: You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, and you will not have to file claims.</p> <p>HDHP Option: You will only pay deductibles and coinsurance and you will not have to file claims.</p>
<ul style="list-style-type: none"> ● Plan providers 	<p>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.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.</p>
<ul style="list-style-type: none"> ● Plan Facilities 	<p>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 Web site.</p>
<ul style="list-style-type: none"> ● Out-of-network providers and facilities 	<p>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.</p>
What you must do to get covered care	<p>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.</p> <p>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.</p>
<ul style="list-style-type: none"> ● Primary care 	<p>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.</p> <p>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.</p>

<ul style="list-style-type: none"> ● Specialty care 	<p>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 <i>obstetrician/gynecologist without a referral</i>.</p> <p>Here are some other things you should know about specialty care:</p> <ul style="list-style-type: none"> ● 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. Your primary care physician will decide what treatment you need. 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: <ul style="list-style-type: none"> – Terminate our contract with your specialist for other than cause; or – Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or – Reduce our service area and you enroll in another FEHB Plan. <p>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.</p> <p>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.</p>
<ul style="list-style-type: none"> ● Hospital care 	<p>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.</p> <p>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.</p>

	<p>If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:</p> <ul style="list-style-type: none"> ● You are discharged, not merely moved to an alternative care center; or ● 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. <p>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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.</p> <p>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 1-800-344-8858.</p>
<p>How to get approval...</p>	
<ul style="list-style-type: none"> ● How to precertify an admission 	<p>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.</p> <p>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.</p> <p>Other services requiring precertification include:</p> <ul style="list-style-type: none"> ● 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 <p>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.</p>
	<p>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 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/or if outpatient surgery is required.</p>

	<p>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.</p> <p>Failure to meet pre-certification requirements for Non-Panel Hospital admissions will result in a reduction of benefits.</p>
<p>Circumstances beyond our control</p>	<p>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</p>
<p>Services requiring our prior approval</p>	<p>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:</p> <p>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.</p> <p>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 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.</p> <p>When a referral is not approved, or the above procedure is not followed, benefits are payable as outlined for other Non-AultCare Providers.</p> <p>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.</p>

Section 4 Your costs for covered services

You must share the costs of some services. You are responsible for:

Copayments	<p>HMO Option: A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.</p> <p>Example: When you see your physician you pay a copayment of \$10 per visit.</p> <p>HDHP Option: There are no copayments in the HDHP.</p>
Deductible	<p>HMO Option: There is no deductible under the HMO.</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>And, 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.</p>
Coinsurance	<p>HMO Option: There is no coinsurance under the HMO.</p> <p>HDHP Option: Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.</p> <p>Example: You pay 20% of our allowance for a Preferred Provider</p> <p>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.</p> <p>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).</p>
Your catastrophic protection out-of-pocket maximum	<p>HMO Option: There is no catastrophic protection out of pocket maximum.</p> <p>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.</p> <p>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.</p>

<p>Your catastrophic protection out-of-pocket maximum (<i>continued</i>)</p>	<p>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.</p> <p>Out-of-pocket expenses for the purposes of this benefit are:</p> <ul style="list-style-type: none"> ● 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 <p>The following cannot be included in the accumulation of out-of-pocket expenses:</p> <ul style="list-style-type: none"> ● Expenses in excess of our allowance or maximum benefit limitations ● Expenses for out-of-network mental health or substance abuse ● 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
<p>Carryover</p>	<p>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.</p> <p>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 of your new option.</p>
<p>Differences between our allowance and the bill</p>	<p>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).</p> <p>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.</p> <p>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.</p>

Differences between our allowance and the bill
(continued)

The following table illustrates the examples of how much you have to pay out-of-pocket for services from an in-network physician vs. an out-of-network physician. The table uses our example of a service for which the physician charges \$150 and our allowance is \$100. The table shows the amount you pay if you have met your calendar year deductible.

Example	In-network physician	Out-of-network physician
Physician's charge	\$150	\$150
Our allowance	We set it at: 100	We set it at: 100
We pay	80% of our allowance: 80	60% of our allowance: 60
You owe: Coinsurance	20% of our allowance: 20	40% of our allowance: 40
+Difference up to charge?	No: 0	Yes: 50
TOTAL YOU PAY	\$20	\$90

When Government facilities bill us

Facilities of the Department of Veteran 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.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Section 5.1 HMO 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 at our Web site at www.aultcare.com.

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Section 5.1(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	
Professional services of physicians <ul style="list-style-type: none"> ● In physician’s office ● In an urgent care center ● Office medical consultations ● Second surgical opinion 	\$10 per office visit
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> ● Blood tests ● Urinalysis ● Non-routine pap tests ● Pathology ● X-rays ● Non-routine Mammograms ● CAT Scans/MRI ● Ultrasound ● Electrocardiogram and EEG 	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit

HMO Option

Preventive care, adult	You pay
Routine physical every year; which includes: Routine Screenings, such as: <ul style="list-style-type: none"> ● Physicals ● Total Blood Cholesterol ● Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 	\$10 per office visit
Routine Prostate Specific Antigen (PSA) test	\$10 per office visit
Routine Pap test Note: The office visit is covered if pap test is received on the same day (see <i>Diagnosis and Treatment</i> , above.)	\$10 per office visit
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> ● 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
Routine immunizations, such as: <ul style="list-style-type: none"> ● Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) ● Influenza vaccine, annually ● Pneumococcal vaccine, age 65 and older 	Nothing
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel</i>	<i>All charges.</i>
Preventive care, children	
<ul style="list-style-type: none"> ● Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing
<ul style="list-style-type: none"> ● Well-child care charges for routine examinations, immunizations and care (up to age 22) ● Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22) 	\$10 per office visit

HMO Option

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> ● Prenatal care ● Delivery ● Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> ● 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 (delivery) the same as for illness and injury. See Hospital benefits (Section 5.1c) and Surgery benefits (Section 5.1b). 	<p>Nothing</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges.</i></p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> ● Voluntary sterilization (See <i>Surgical procedures</i> Section 5.1b) ● Surgically implanted contraceptives ● Injectable contraceptive drugs (such as Depo provera) ● Intrauterine devices (IUDs) ● Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Reversal of voluntary surgical sterilization</i> ● <i>Genetic counseling</i> ● <i>Elective abortion</i> 	<p><i>All charges.</i></p>

HMO Option

Infertility services	You pay
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> ● Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) ● Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> ● <i>Services and supplies related to ART procedures</i> ● <i>Cost of donor sperm</i> ● <i>Cost of donor egg</i> 	All charges.
Allergy care	
<ul style="list-style-type: none"> ● Testing and treatment ● Allergy injections ● Allergy serum 	Nothing
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<i>All charges.</i>

HMO Option

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 30.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>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 <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$10 per office visit</p>
Physical and occupational therapies	
<p>60 visits per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided. 	<p>\$10 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges.</i></p>
Speech therapy	
<p>60 visits per condition for the services of speech therapists.</p>	<p>\$10 per office visit</p>

HMO Option

Hearing services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them 	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	
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.	\$10 per office visit
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	\$10 per office visit
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children and adults <p>Coverage includes:</p> <ul style="list-style-type: none"> • 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 	\$10 per office visit All charges. over the maximum Plan payments
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eye exams from an optometrist • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery 	<i>All charges.</i>

HMO Option

Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>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</i> ● <i>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)</i> 	<i>All charges.</i>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> ● Artificial limbs and eyes; stump hose ● Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy ● 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 5.1(c) for payment information. Insertion of the device is paid as surgery; see Section 5.1(b) for coverage of the surgery to insert the device. ● Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Orthopedic and corrective shoes</i> ● <i>Arch supports</i> ● <i>Heel pads and heel cups</i> ● <i>Lumbosacral supports</i> ● <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> 	<i>All charges.</i>

HMO Option

Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheel Chairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>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.</p>	Nothing
<i>Not covered: Motorized wheelchairs</i>	<i>All charges.</i>
Home health services	
<ul style="list-style-type: none"> • 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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> 	<i>All charges.</i>
Chiropractic	
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$10 per office visit
<i>Not covered: Maintenance care</i>	<i>All charges.</i>
Alternative treatments	
<i>No Benefit.</i>	<i>All charges.</i>

**Section 5.1(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 amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5.1(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF 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
<p>Surgical procedures</p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> ● 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 <i>Reconstructive surgery</i>) ● Treatment of morbid obesity (bariatric surgery) <p>Eligible members must show each of the following criteria is present:</p> <ul style="list-style-type: none"> — 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 multidisciplinary approach including medical, psychiatric, nutritional, exercise, psychological, and supportive consultations and counseling <ul style="list-style-type: none"> ● Insertion of internal prosthetic devices. See Section 5.1(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information <p>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.</p>	<p>Nothing</p>
<p><i>Not covered: Reversal of voluntary sterilization</i></p>	<p><i>All charges.</i></p>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> ● Surgery to correct a functional defect ● Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> — 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: <ul style="list-style-type: none"> — surgery to produce a symmetrical appearance of breasts; — treatment of any physical complications, such as lymphedemas; — breast prostheses and surgical bras and replacements (see <i>Orthopedic Prosthetic devices</i>) <p>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.</p>	<p>\$10 per office visit; nothing for hospital visits</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>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</i> ● <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> ● 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 	<p>\$10 per office visit; nothing for hospital visits</p>

Oral and maxillofacial surgery-continued on the next page

HMO Option

Oral and maxillofacial surgery (continued)	You pay
<ul style="list-style-type: none"> ● TMJ treatment and services(non-dental); and ● Other surgical procedures that do not involve the teeth or their supporting structures 	\$10 per office visit; nothing for hospital visits
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Oral implants and transplants</i> ● <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges.</i>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> ● Cornea ● Heart ● Heart/lung ● Kidney ● Kidney/Pancreas ● Liver ● Lung: Single – Double ● Pancreas ● Allogeneic (donor) bone marrow transplants ● Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors ● Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas ● Autologous tandem transplants for testicular tumors and other germ cell tumors ● National Transplant Program (NTP) <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We coordinate insurance related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing

Organ/tissue transplant-continued on the next page

HMO Option

Organ/tissue transplants (continued)	You pay
<i>Not covered:</i> <ul style="list-style-type: none">• Donor screening tests and donor search expenses, except those performed for the actual donor• Implants of artificial organs• Transplants not listed as covered	<i>All charges.</i>
Anesthesia	
Professional services provided in – <ul style="list-style-type: none">• Hospital (Inpatient)• Hospital (Outpatient)• Skilled Nursing facility• Ambulatory surgical center• Office	Nothing

Section 5.1(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 5.1(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HDHP HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: <ul style="list-style-type: none"> ● Ward, semiprivate, or intensive care accommodations; ● General nursing care; and ● 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.	Nothing
Other hospital services and supplies, such as: <ul style="list-style-type: none"> ● 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: <ul style="list-style-type: none"> ● Custodial care ● Personal comfort items, such as telephone, television, barber services, guest meals and beds ● Private nursing care, except when medically necessary 	All charges.

HMO Option

Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> ● 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 <p>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.</p>	Nothing
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefit:</p> <p>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:</p> <ul style="list-style-type: none"> ● 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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● Custodial care ● Rest Cures ● Domiciliary ● Convalescent care 	<i>All charges.</i>
Hospice care	
<ul style="list-style-type: none"> ● Supportive and palliative care ● Inpatient and outpatient care ● Family counseling <p>Note: limited to life expectancy of six (6) months or less</p>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>
Ambulance	
<ul style="list-style-type: none"> ● Local professional ambulance service when medically appropriate 	Nothing

Section 5.1(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 or outside our service area	
<ul style="list-style-type: none"> • 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 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> 	<i>All charges.</i>
Ambulance	
<p>Professional ambulance service when medically appropriate. Note: See 5.1(c) for non-emergency service.</p>	Nothing

Section 5.1(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan 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.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>\$10 per office visit; nothing if you receive these services during your office visit; otherwise,</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>Nothing</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: 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.</i></p>	<p><i>All charges.</i></p>

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

All non-AultCare admissions, partial hospitalizations programs and intensive out-patient programs require preauthorization. For preauthorization, call 1-800-344-8858.

Section 5.1(f) Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.
- Certain drugs require prior authorization where your physician will submit a letter of medical necessity. For a list of these drugs, call 1-800-344-8858.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **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 retail.

During a National emergency or call to active military duty requiring an extended supply of prescription drugs, call 1-800-344-8858.

- **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.

Prescription drug benefits begin on the next page

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy.</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • 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 • 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 • Smoking cessation drugs up to an annual \$200 maximum per member • Growth hormone 	<p>\$10 copayment for a generic drug</p> <p>\$20 copayment for a brand name drug on the Plan’s formulary</p> <p>\$35 copayment for a brand name drug not on the Plan’s formulary.</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Non-prescription medicines</i> • <i>Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies</i> • <i>Medical supplies such as dressings and antiseptics</i> 	<p><i>All charges.</i></p>

Section 5.1(g) Special features

Feature	Description
Aultman Healthline	For any of your health concerns, 7 days a week, you may call 1-800-393-9337 and talk with a registered nurse who will discuss treatment options and answer your health questions.
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. 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.

Section 5.1 (h) 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.
- 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 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.**

Accidental injury benefit	You pay
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	
<p>Preventive and Diagnostic</p> <ul style="list-style-type: none"> • 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 	30% of allowable charges
<p>Basic Restorative</p> <ul style="list-style-type: none"> • Restorative • Endodontics • Periodontics • Oral Surgery • Prosthodontics 	30% of allowable charges
<p>Major Restorative</p> <ul style="list-style-type: none"> • Full and partial dentures • Fixed bridges • Crowns • Inlays 	30% of allowable charges
<i>Not Covered: Other dental services not shown as covered</i>	<i>All charges.</i>

Section 5.1(i) 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.

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

Aultman Alternatives

Aultman Alternatives is committed to health promotion and disease prevention. Programs are offered to individuals and businesses designed to help participants learn to control risk factors and make healthier decisions. Weight management and healthy nutrition programs are developed and presented by medical professionals and are approved by a physician steering committee. Day and evening sessions are available for most classes. Call 330-363-6209 for fee and registration information.

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.

Section 5.2 High Deductible Health Plan Benefits

See page 10 for how our benefits changed this year and page 100 for the benefits summary.

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Section 5.2 High Deductible Health Plan Benefits 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 5.2, which describes the HDHP benefits, is divided into subsections. Please read that important things you should keep in mind 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 at our Web site 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 based upon your eligibility.

Before your pay towards your deductible, preventive medical care is covered up to the Plan maximums or in full depending on the service. When you receive other non-preventive medical care, you must meet the Plan’s deductible before we pay benefits according to the benefits outlined in this brochure. 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.

<ul style="list-style-type: none"> Preventive care 	<p>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. These services are fully described in section 5.2(a) You do not have to meet the deductible before using these services.</p>
<ul style="list-style-type: none"> Traditional medical care 	<p>After you have paid the Plan’s deductible, we pay benefits under traditional in-network coverage described in Section 5.2. The Plan typically pays 80% for in-network and 60% for out-of-network care.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> Savings 	<p>Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 45 for more details).</p>

Health Savings Accounts (HSA)

By law, Health Saving Accounts 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 Benefits within the last three months or do not have other health insurance coverage. In 2006, 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 \$2,000 for a self only and \$4,000 for a self and family. See maximum contribution information on page 47. 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 First HSA.
- Your contributions to the HSA are tax deductible
- Your HSAI 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:

If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a healthcare flexible spending account (such as FSA, FEDS, offers-see Section 12), this HDHP cannot continue to contribute to your HSA. Instead, when you inform us of your coverage in an FSA, 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 in eligible for an HSA.

In 2006, 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

Health Reimbursement Arrangement (HRA) continued next page

<p>Health Reimbursement Arrangements (HRA) <i>(continued)</i></p>	<ul style="list-style-type: none"> • 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. <p>An HRA does not affect your ability to participate in an <i>FSAFEDS</i> Health Care Flexible Spending Account (HCFSAs). However, you must meet <i>FSAFEDS</i> eligibility requirements. See <i>Who is eligible to enroll?</i> In Section 12 of the Federal Flexible Spending Account Program—<i>FSAFEDS</i>.</p>
<ul style="list-style-type: none"> • Catastrophic protection for out-of-pocket expenses 	<p>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. 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 <i>Your catastrophic protection out-of-pocket maximum</i>, Section 5.2 <i>Traditional medical coverage subject to the deductible</i> for more details.</p>
<ul style="list-style-type: none"> • Health education resources and account management tools 	<p>Section 5.2(h) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.</p>

Section 5.2 Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Custodian	<p>The Plan will establish an HSA for you with First HSA, this HDHP’s custodian as defined by Federal tax code and approved by IRS.</p> <p><i>First HSA</i> <i>1044 MacArthur Road</i> <i>Reading ,PA 19605</i> <i>Phone(610)678-6000 or www.firsthsa.com</i></p>	<p><i>AultCare Health Plan</i> is the HRA fiduciary for this Plan.</p> <p><i>AultCare</i> <i>2600 Sixth Street SW P.O. Box 6910</i> <i>Canton, OH 44706</i> <i>1-800-344-8858 or www.aultcare.com</i></p>
Fees	<p>Set-up fee is paid by the HDHP. No additional cost to the member.</p>	<p><i>AultCare Health Plan</i> None.</p>
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> ● 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 Part A or Part B ● Not be claimed as a dependent on someone else’s tax return ● Must not have received VA benefits in the last three months ● Complete and return all banking paperwork. <p>Eligibility for contributions is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment.</p>	<p>You must enroll in this HDHP.</p> <p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>
Funding	<p>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.</p>	<p>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.</p>

<ul style="list-style-type: none"> • Self Only enrollment 	<p>For 2006, a monthly premium pass through of \$83.33 will be made by the HDHP directly into your HSA each month</p>	<p>For 2006, your HRA annual credit is \$1,000 (prorated by length of enrollment).</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>For 2006, a monthly premium pass through of \$166.66 will be made by the HDHP directly into your HSA each month.</p> <p>Eligibility for contributions is determined on the first day of the month following your effective date of your enrollment in the HDHP.</p>	<p>For 2006, your HRA annual credit is \$2,000 (prorated by length of enrollment).</p>
<ul style="list-style-type: none"> • Contributions/credits 	<p>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 amount of the deductible, which is \$2,000 self and \$4,000 self and family.</p> <p>For each month you are eligible for HSA contributions, if you choose to contribute to your HSA,</p> <ul style="list-style-type: none"> – The maximum allowable contribution is a combination of employee and employer funds up to the amount of the deductible \$2,000.00 for Self only or \$4,000.00 for Self and Family. To determine the maximum allowable contribution, take the amount of your deductible divided by 12, times the number of full months enrolled in the HDHP. Subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution to determine the amount you may contribute. – 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). – HSA earn tax-free interest (does not affect your annual maximum contribution). – Catch-up contribution discussed on page 50 	<p>The full HRA credit will be available, subject, to proration, on the effective date of enrollment. The HRA does not earn interest.</p>

HDHP Option

<ul style="list-style-type: none"> • Self Only enrollment 	<p>You may make an annual maximum contribution of \$1,000.00</p>	<p>You cannot contribute to the HRA.</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>You may make an annual maximum contribution of \$2,000.00</p>	<p>You cannot contribute to the HRA.</p>
<ul style="list-style-type: none"> • Access funds 	<p>You can access your HSA by the following methods :</p> <ul style="list-style-type: none"> – Debit card – Withdrawal form – Checks 	<p>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.</p>
<p>Distributions/withdrawals</p> <ul style="list-style-type: none"> • Medical 	<p>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.</p> <p>See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>

<ul style="list-style-type: none"> Non-medical 	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses</p>
<p>Availability of funds</p>	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> 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 HAS The fiduciary sends out HSA paperwork for the enrollee to complete and the fiduciary receives the completed paperwork. 	<p>The HRA credit will be available, subject to proration, on the effective date of enrollment.</p>
<p>Account owner</p>	<p>FEHB enrollee</p>	<p>HDHP</p>
<p>Portable</p>	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll n another HDHP, you can no longer contribute to your HSA.</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>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.</p>
<p>Annual rollover</p>	<p>Yes, accumulates without a maximum cap.</p>	<p>Yes, accumulates without a maximum cap.</p>

<p>If you have an HSA</p>	
<ul style="list-style-type: none"> ● Contributions 	<p>All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your account through payroll deductions (if available), or you may make a lump sum contribution at any time, in any amount up to an annual maximum limit. Others can also make contributions to your HSA on your behalf. If you (or someone on your behalf) contribute a lump-sum, you can claim the total amount contributed for the year as a tax deduction when you file your income taxes. You receive tax advantages in any case. You have until April 15 of the following year to make HSA contributions for the current year.</p> <p>IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2006, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution. Contact First HSA for more details.</p>
<ul style="list-style-type: none"> ● Catch-up contributions 	<p>If you are age 55 or older, the IRS permits you to make additional catch-up contributions to your HSA. In 2006, you may contribute up to \$700 in “catch-up” contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is eligible for Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.</p>
<ul style="list-style-type: none"> ● If you die 	<p>If you do not have a main beneficiary, if you are married it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.</p>
<ul style="list-style-type: none"> ● Qualified expenses 	<p>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, and health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.</p> <p>When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.</p> <p>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 Web site at www.irs.gov and click on “Forms and Publications.” Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.</p>
<ul style="list-style-type: none"> ● Non-qualified expenses 	<p>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 10% penalty tax on the amount withdrawn.</p>
<ul style="list-style-type: none"> ● Tracking your HSA balance 	<p>You will receive a periodic statement that shows the “premium pass through” and withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.</p>
<ul style="list-style-type: none"> ● Minimum reimbursements from your HSA 	<p>You can request reimbursement in any amount.</p>

If you have an HRA	
<ul style="list-style-type: none">• Why an HRA is established	If you don't qualify for an HSA when you enroll, or later become ineligible for an HSA, the HDHP 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.
<ul style="list-style-type: none">• How an HRA differs	Please review the chart on page 46 which details the differences between an HRA and an HSA. The major differences are: <ul style="list-style-type: none">• You cannot make contributions to an HRA• Funds are forfeited if you leave the HDHP• an HRA does not earn interest, and• HRA can only pay for qualified medical expenses, such as deductibles, and coinsurance expenses, for individuals covered by the HDHP.

Section 5.2 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 only owe your copay for covered preventive care services.
- You must use providers that are part of our network.
- For all other covered expenses, please see Section 5.2 - *Traditional medical coverage subject to the deductible.*

Benefits Description	You pay
Preventive care, adult	
<p>Professional services, such as:</p> <ul style="list-style-type: none"> • Routine physicals/Routine gynecological/prostate Note: limited to a combined \$200 per calendar year. • Routine Pap • Routine mammograms Note: limited to \$85 per calendar year. • Routine immunizations, such as : <ul style="list-style-type: none"> – Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) – Influenza vaccine, annually – Pneumococcal vaccine, age 65 and older • Routine prenatal care 	<p>In network: 100% over plan allowance.</p> <p>Out-of-network: 50% of the plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, or travel.</i> • <i>Immunizations, boosters, and medications for travel.</i> 	<p><i>All charges.</i></p>

Preventive care, children	You pay
<p>Professional services, such as:</p> <ul style="list-style-type: none"> ● Well-child visits for routine examinations, immunizations and care up to 12 months then physical exam. ● Childhood immunizations recommended by the American Academy of Pediatrics ● Eye exam to determine the need for vision correction for children through age 17. <p>Note: See Vision services</p>	<p>In-network: Nothing</p> <p>Out-of-network: 50% of any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> ● <i>Immunizations, boosters, and medications for travel.</i> 	<p><i>All charges.</i></p>

Section 5.2 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 5.2 (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 5.2. 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).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits 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.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the <i>You pay</i> 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.	<p>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.</p> <p>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.</p>

Section 5.2(a) Medical services and supplies provided by physicians and other healthcare 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 deductible is \$2,000 Self Only or \$4,000 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	
Professional services of physicians <ul style="list-style-type: none"> ● In physician’s office ● In an urgent care center for routine services ● During a hospital stay ● In a skilled nursing 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
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> ● Blood tests ● Urinalysis ● Non-routine pap tests ● Pathology ● X-rays ● Non-routine Mammograms ● CAT Scans/MRI ● Ultrasound ● Electrocardiogram and EEG 	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

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care (see <i>Section 5.2(a) Preventive care</i>) • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • 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 (delivery) the same as for illness and injury. See <i>Hospital benefits</i> in Section 5.2 (c) and <i>Surgery benefits</i> in Section 5.2 (b). 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Note: Prenatal care is covered under <i>Preventive Care</i> (not subject to the deductible)</p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (see <i>Surgical procedures</i> Section 5.2) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization.</i> • <i>Elective abortion</i> 	<p><i>All charges.</i></p>

Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> ● Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) ● Fertility drugs <p>Note: We cover injectible and oral fertility drugs under medical benefits and oral fertility drugs under the medical drug benefit.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>In vitro fertilization</i> – <i>Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> ● <i>Services and supplies related to ART procedures</i> ● <i>Cost of donor sperm</i> ● <i>Cost of donor egg</i> 	

Allergy care	You pay
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Allergy Serum</p>	<p>In-network: Nothing</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges.</i></p>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 66.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the medical plan.</p> <p>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 <i>Services requiring our prior approval</i> in Section 3.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
Physical and occupational therapies	
<p>60 visits per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges.</i></p>

Speech therapy	You pay
60 visits per condition for the services 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
Hearing services (testing, treatment and supplies)	
<ul style="list-style-type: none"> • First <i>hearing aid and testing only when necessitated by accidental injury</i> • Hearing <i>testing for children through age 17 (see Preventive care, children)</i> 	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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All <i>other hearing testing</i> • Hearing <i>aids, testing and examinations for them</i> 	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children through age 17 <p>Note: See Preventive care, children for eye exams for children.</p>	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
<p><i>Not covered services over age 17:</i></p> <ul style="list-style-type: none"> • <i>Eye exams from an optometrist</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery:</i> 	<i>All charges.</i>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	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

Foot care continued next page

Foot care (continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● 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) 	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> ● Artificial limbs and eyes; stump hose ● Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy ● Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. <p>Note: Internal prosthetic devices are paid as hospital benefits; see Section 5.2 for payment information. Insertion of the device is paid as surgery; see Section 5.2(b) for coverage of the surgery to insert the device.</p> <ul style="list-style-type: none"> ● Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● Orthopedic and corrective shoes ● Arch supports ● Foot orthotics ● Heel pads and heel cups ● Lumbosacral supports ● Corsets, trusses, elastic stockings, support hose, and other supportive devices 	<p><i>All charges.</i></p>

Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>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.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • <i>Not covered: Motorized wheelchairs.</i> 	<p><i>All charges.</i></p>
Home health services	
<ul style="list-style-type: none"> • 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. <p>Services include oxygen therapy, intravenous therapy and medications.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> 	<p><i>All charges.</i></p>

Chiropractic	You pay
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered: Maintenance care</i></p>	<p><i>All charges.</i></p>
Alternative treatments	
<p><i>No Benefit.</i></p>	<p><i>All charges.</i></p>
Educational classes and programs	
<ul style="list-style-type: none"> • Smoking Cessation – Up to \$200 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>

Section 5.2(b) Surgical and anesthesia services provided by physicians and other healthcare 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 deductible is \$2,000 Self Only or \$4,000 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.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5.2(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	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 <i>Reconstructive surgery</i>) 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>

Surgical procedures continued next page

Surgical procedures (continued)	You pay
<ul style="list-style-type: none"> ● Treatment of morbid obesity (bariatric surgery) Eligible members must show each of the following criteria is present: <ul style="list-style-type: none"> – 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 multidisciplinary approach including medical, psychiatric, nutritional, exercise, psychological, and supportive consultations and counseling ● Insertion of internal prosthetic devices. See Section 5.1(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information ● Voluntary sterilization (e.g., Tubal ligation, Vasectomy) ● Treatment of burns <p>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.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not Covered: Reversal of voluntary sterilization</i></p>	<p><i>All charges.</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> ● Surgery to correct a functional defect ● Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery <p>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.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>

Reconstructive surgery continued next page

Reconstructive surgery (continued)	You pay
<ul style="list-style-type: none"> ● All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – 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) <p>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.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>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</i> ● <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> ● 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. 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Oral implants and transplants</i> ● <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone)</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Autologous tandem transplants for testicular tumors and other germ cell tumors • National Transplant Program (NTP) <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We coordinate insurance related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • Transplants not listed as covered 	<p><i>All charges.</i></p>

Anesthesia	
Professional services provided in – <ul style="list-style-type: none">• Hospital (inpatient)• Hospital (outpatient)• 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 5.2(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 deductible is \$2,000 Self Only enrollment and or \$4,000 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.
- 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 5.2(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF OUT-OF-NETWORK INPATIENT ADMISSIONS, SKILLED NURSING FACILITIES AND HOME HEALTH CARE; FAILURE TO DO SO MAY RESULT IN A MINIMUM OF 50% 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	
Room and board, such as: <ul style="list-style-type: none"> ● Ward, semiprivate, or intensive care accommodations; ● General nursing care; and ● 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.	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 continued on next page

Inpatient hospital (continued)	You pay
<ul style="list-style-type: none"> • 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 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care, except when medically necessary</i> 	<p><i>All charges.</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • 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 <p>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.</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>

Extended care benefits/Skilled nursing facility (SNF) benefits	You pay
<p>Extended care benefit:</p> <p>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:</p> <ul style="list-style-type: none"> • 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 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Rest Cures</i> • <i>Domiciliary</i> • <i>Convalescent care</i> 	<p><i>All charges.</i></p>
<p>Hospice care</p>	
<ul style="list-style-type: none"> • Supportive and palliative care • Inpatient and outpatient care • Family counseling <p>Note: limited to life expectancy of six (6) months or less</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges.</i></p>
<p>Ambulance</p>	
<p>Local professional ambulance service when medically appropriate</p>	<p>20% of the Plan allowance and any difference between our allowance and the billed amount</p>

Section 5.2(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 deductible is \$2,000 Self Only enrollment and or \$4,000 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 our service area	You pay
<ul style="list-style-type: none"> ● 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 	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Elective care or non-emergency care</i> ● <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> 	<p><i>All charges.</i></p>
Emergency outside our service area	
<p>Emergency care at a doctor’s office</p> <p>Emergency care at an urgent care center</p> <p>Emergency care as an outpatient at a hospital, including doctor’s services</p>	<p>In-network: 20% of the Plan allowance</p> <p>Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Elective care or non-emergency care</i> ● <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> 	<p><i>All charges.</i></p>

Section 5.2(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for in-network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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 deductible is \$2,000 Self Only enrollment and or \$4,000 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.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits	
In-network benefits	You pay
<p>All diagnostic and treatment services recommended by a network provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: In-network 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.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	In-network: 20% of the Plan allowance.

Mental health and substance abuse benefits continued on next page

Mental health and substance abuse benefits (continued)	You pay
<ul style="list-style-type: none"> Diagnostic tests 	In-network: 20% of the Plan allowance.
<ul style="list-style-type: none"> Services provided by a hospital or other facility Inpatient care to treat mental conditions includes ward or semiprivate accommodations and other hospital charges Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	In-network: 20% of the Plan allowance
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: 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.</i></p>	<i>All charges.</i>

Preauthorization To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

All out-of-network admissions, partial hospitalizations programs and intensive out-patient programs require preauthorization. For preauthorization, call 1-800-344-8858.

Limitation We will provide out-of-network benefits, if you do not obtain a treatment plan.

Out-of-network benefits	You pay
Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers Medication management	Out-of-network: 40% of plan allowance up to 30 visits per calendar year; All charges. after 30 visits per calendar year:
Diagnostic tests	Out-of-network: 40% of the Plan allowance up to 30 visits per calendar year; All charges. after 30 visits per calendar year.
Services provided by a hospital or other facility Inpatient care to treat mental conditions includes ward or semiprivate accommodations and other hospital charges Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Out-of-network: 40% of the Plan allowance up to 30 days per calendar year; All charges. after 30 days per calendar year.
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: 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.</i></p>	<p><i>All charges.</i></p>

Lifetime maximum Alcohol/Substance Abuse Inpatient Care and Outpatient Treatment Programs are limited to a lifetime maximum of \$50,000 with the exception of a minimum annual \$550 benefit for treatment of alcoholism.

Preauthorization To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

All out-of-network admissions, partial hospitalizations programs and intensive out-patient programs require preauthorization. For preauthorization, call 1-800-344-8858.

Section 5.2(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described on page 76.
- 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 deductible is \$2,000 Self Only enrollment and or \$4,000 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 prescription.** A licensed physician or licensed physician must write the prescription
- **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.

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.

During a National emergency or call to active military duty requiring an extended supply of prescription drugs call 1-800-344-8858.

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.

When you do have to file a claim. When you do not use your prescription drug card.

Prescription drug benefits begin on the next page

Prescription drugs	
Benefit Description	You pay After the calendar year deductible...
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy.</p> <ul style="list-style-type: none"> ● Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. ● 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 ● Smoking cessation drugs up to an annual \$200 maximum per member ● Growth hormone 	<p>Using Prescription card: 20% of discounted amount.</p> <p>Not using Prescription drug card: 20% of plan allowance. No applicable discount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Drugs and supplies for cosmetic purposes</i> ● <i>Drugs to enhance athletic performance</i> ● <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> ● <i>Nonprescription medicines</i> ● <i>Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies</i> ● <i>Medical supplies such as dressings and antiseptics</i> 	<p><i>All charges.</i></p>

Section 5.2(g) Special features

Feature	Description
Aultman Healthline	For any of your health concerns, 7 days a week, you may call 1-800-393-9337 and talk with a registered nurse who will discuss treatment options and answer your health questions.
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. 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.

Section 5.2(h) Health education resources and account management tools

Special features	Description
<p>Health education resources</p>	<p>The Aultman Institute publishes a newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at www.aultman.com.</p> <p>Visit this Web site www.aultman.com for information on:</p> <ul style="list-style-type: none"> General health topics Links to health care news Cancer and other specific diseases Drugs/medication interactions Kids' health Patient safety information <p>and several helpful Web site links.</p>
<p>Account management tools</p>	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through www.aultcare.com.</p> <p>Your balance will also be shown on your explanation of benefits (EOB) form.</p> <p>You will receive an EOB after every claim.</p> <p>If you have an HSA,</p> <ul style="list-style-type: none"> ✓ You will receive a monthly bank statement from first HSA outlining your account balance and activity for the month. ✓ You may also access your account on-line at www.firsthsa.com <p>If you have an HRA,</p> <ul style="list-style-type: none"> ✓ Your HRA balance will be available online through www.aultcare.com ✓ Your balance will also be shown on your EOB form.
<p>Consumer choice information</p>	<p>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</p> <p>Link to online pharmacy through www.aultcare.com</p>
<p>Care support</p>	<p>Patient safety information is available online at www.aultcare.com</p> <p>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.</p>

Section 5.2(i) 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.

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

Aultman Alternatives

Aultman Alternatives is committed to health promotion and disease prevention. Programs are offered to individuals and businesses designed to help participants learn to control risk factors and make healthier decisions. Weight management and healthy nutrition programs are developed and presented by medical professionals and are approved by a physician steering committee. Day and evening sessions are available for most classes. Call 330-363-6209 for fee and registration information.

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.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

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; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

When you see network physicians, receive services at network hospitals and facilities, or obtain your prescription drugs at network 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 out-of-network 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	<p>In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility must file on the UB-92 form. For claims questions and assistance, call us at 1-800-344-8858.</p> <p>When you must file a claim – such as for services you receive outside of the Plan’s service area– submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:</p> <ul style="list-style-type: none"> ● Covered member’s name 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; and ● A copy of the explanation of benefits, payments, or denial from any primary payer-such as the Medicare Summary Notice (MSN); and ● Receipts, if you paid for your services. Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills. <p>Submit your claims to: AultCare Health Plan 2600 Sixth Street SW Canton, Ohio 44710 1-800-344-8858</p>
Records	<p>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</p>
Deadline for filing your claim	<p>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.</p>
Overseas claims	<p>For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Claim Form and the itemized bills to: AultCare Health Plan, 2600 Sixth Street SW, Canton, Ohio 44710.</p>
When we need more information	<p>Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.</p>

Section 8 The disputed claims process

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. Disagreements between you and the HDHP custodian regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> 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.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> 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.
3	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p>
	<p>You must write to OPM within:</p> <ul style="list-style-type: none"> • 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.
	<p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The disputed claims process continued on next page

The disputed claims process *(continued)*

	<p>Send OPM the following information:</p> <ul style="list-style-type: none"> ● 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. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>
	<p>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.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
5	<p>OPM will review your disputed claim request 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.</p>
	<p>If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, 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.</p> <p>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.</p>
	<p>You may not sue 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.</p>

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-344-8858 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. Eastern time.

Section 9 Coordinating benefits with other coverage

<p>When you have other health coverage</p>	<p>You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”</p> <p>When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.</p> <p>When we are the primary payer, we will pay the benefits described in this brochure.</p> <p>When we are the secondary payer, 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.</p>
<p>What is Medicare?</p>	<p>Medicare is a Health Insurance Program for:</p> <ul style="list-style-type: none"> ● 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). <p>Medicare has four parts:</p> <ul style="list-style-type: none"> ● 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE 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. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). 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. The notice will give you guidance on enrolling in Medicare Part D.

<ul style="list-style-type: none"> • Should I enroll in Medicare? 	<p>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 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.</p> <p>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.</p>
<ul style="list-style-type: none"> • The Original Medicare Plan (Part A or Part B) 	<p>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.</p> <p>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.</p> <p>Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.</p> <p>When we are the primary payer, we process the claim first.</p> <p>When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800-344-8858 or see our Web site at www.aultcare.com.</p> <p>We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:</p> <ul style="list-style-type: none"> • Medical services and supplies provided by physicians and other health care professionals. <p>We do not waive any costs if the Original Medicare Plan is your primary payer.</p>
<ul style="list-style-type: none"> • Medicare Advantage (Part C) 	<p>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) or at www.medicare.gov.</p> <p>If you enroll in a Medicare Advantage plan, the following options are available to you:</p> <p>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), but 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. Medicare Advantage (Part C)</p> <p>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.</p>
<ul style="list-style-type: none"> • Medicare prescription drug coverage (Part D) 	<p>When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, 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.</p>

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer 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.

Primary Payer Chart

A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
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...		✓ for 30-month coordination period
• This Plan was the primary payer before eligibility due to ESRD		
• Medicare was the primary payer before eligibility due to ESRD	✓	
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

<p>TRICARE and CHAMPVA</p>	<p>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.</p> <p>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 the program.</p>
<p>Workers' Compensation</p>	<p>We do not cover services that:</p> <ul style="list-style-type: none"> • You 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. <p>Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.</p>
<p>Medicaid</p>	<p>When you have this Plan and Medicaid, we pay first.</p> <p>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.</p>
<p>When other Government agencies are responsible for your care</p>	<p>We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.</p>
<p>When others are responsible for injuries</p>	<p>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.</p> <p>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.</p>

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.
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 15.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 15.
Covered services	Services we provide benefits for, as described in this brochure.
Custodial care	<p>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.</p> <p>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</p>
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 15.
Experimental or investigational services	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.
Medical necessity	<p>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:</p> <ul style="list-style-type: none"> ● 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.
Us/We	Us and We refer to AultCare Health Plan
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

<ul style="list-style-type: none"> • No pre-existing condition limitation 	<p>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.</p>
<ul style="list-style-type: none"> • Where you can get information about enrolling in the FEHB Program 	<p>See www.opm.gov/insure/health for enrollment as well as:</p> <ul style="list-style-type: none"> • Information on the FEHB Program and plans available to you • A health plan comparison tool • A list of agencies who participate in Employee Express • A link to Employee Express • Information on and links to other electronic enrollment systems <p>Also, your employing or retirement office can answer your questions, and give you a <i>Guide to Federal Employees Health Benefits Plans</i>, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:</p> <ul style="list-style-type: none"> • 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; • When your enrollment ends; and • When the next open season for enrollment begins. <p>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.</p>
<ul style="list-style-type: none"> • Types of coverage available for you and your family 	<p>Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.</p> <p>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.</p> <p>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 when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.</p> <p>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.</p>

<ul style="list-style-type: none"> • Children’s Equity Act 	<p>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).</p> <p>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:</p> <ul style="list-style-type: none"> • 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 Plan’s Basic Option. <p>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.</p>
<ul style="list-style-type: none"> • When benefits and premiums start 	<p>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 2006 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 2005 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.</p>
<ul style="list-style-type: none"> • When you retire 	<p>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)</p>

When you lose benefits

<ul style="list-style-type: none"> • When FEHB coverage ends 	<p>You will receive an additional 31 days of coverage, for no additional premium, when:</p> <ul style="list-style-type: none"> • Your enrollment ends, unless you cancel your enrollment, or • You are a family member no longer eligible for coverage. <p>You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)</p>
<ul style="list-style-type: none"> • Spouse equity coverage 	<p>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 to you. But, you may be eligible for your own FEHB coverage under 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 <i>Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees</i>, or other information about your coverage choices. You can also download the guide from OPM’s Web site, www.opm.gov/insure.</p>
<ul style="list-style-type: none"> • Temporary Continuation of Coverage (TCC) 	<p>If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after your retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.</p> <p>You may not elect TCC if you are fired from your Federal job due to gross misconduct.</p> <p>Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the <i>Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees</i>, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.</p>
<ul style="list-style-type: none"> • Converting to individual coverage 	<p>You may convert to a non-FEHB individual policy if:</p> <ul style="list-style-type: none"> • Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert); • You decided not to receive coverage under TCC or the spouse equity law; or • You are not eligible for coverage under TCC or the spouse equity law. <p>If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.</p> <p>Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.</p>

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the Federal Flexible Spending Account (FSA) Program, also known as FSAFEDS, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the Federal Long Term Care Insurance Program (FLTCIP) helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – FSAFEDS

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return and who is mentally or physically incapable of self care.
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.

- **Enroll during Open Season**

You must make an election to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled for 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit www.fsafeds.com and click on Enroll.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAFEDS accounts. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “Use-it-or-Lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page xx and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the HMO Option of this plan, typical out-of-pocket expenses include: office visit copays and hearing aids.

Under the High Deductible Health Plan, typical out-of-pocket expenses include: deductibles and chiropractic maintenance care.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note.

Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502. Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the [Dependent Care Tax Credit Worksheet](#) from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance during your period of coverage for the Plan Year plus 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the FSAFEDS Web site at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the HMO AultCare Health Plan 2006

- **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.

HMO Benefits	You pay	Page
Medical services provided by physicians:		
● Diagnostic and treatment services provided in the office	\$10 per office visit	20
Services provided by a hospital:		
● Inpatient	Nothing	32
● Outpatient	Nothing	33
Emergency benefits:		
● In-area	Nothing	34
● Out-of-area	Nothing	34
Mental health and substance abuse treatment:	Regular cost sharing	35
Prescription drugs:		36
● Generic	\$10 copayments	
● Brand name formulary	\$20 copayments	36
● Brand name non-formulary	\$35 copayments	36
Dental care:		
Accidental injury benefit	Nothing	39
Preventive dental care	30%	39
Vision care:		
One exam every two years	\$10 per office visit	25
Eyewear	Various payments	25
Special features: Aultman Healthline, I Can Cope, Common Ground		38

Summary of benefits for the HDHP AultCare Health Plan 2006

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 2006 for each month you are eligible for the HSA, 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 Health Savings Account (HSA), you must satisfy your calendar year deductible of \$2,000 for Self Only and \$4,000 for Self and Family before using your HSA. 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
Medical services provided by physicians: <ul style="list-style-type: none"> • 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.	55
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient 	In-network: 20% of plan allowance Out-of-network: 40% of our allowance plus amount over our allowance.	67
<ul style="list-style-type: none"> • Outpatient 	In-network: 20% of plan allowance Out-of-network: 40% of our allowance plus amount over our allowance.	68
Emergency benefits: <ul style="list-style-type: none"> • In-area • Out-of-area 	In-network: 20% of plan allowance Out-of-network: 40% of our allowance plus amount over our allowance.	71
Mental health and substance abuse treatment:	In-network: regular cost sharing. Out-of-network: Benefits are limited	72
Prescription drugs:	20% of plan allowance	75
Special features: Aultman Healthline, I Can Cope, Common Ground		77
Protection against catastrophic costs (out-of-pocket maximum):	In-network: Nothing after \$2,000/Self Only or \$4,000/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	15

NOTES:

2006 Rate Information for AultCare Health Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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 FEHB Guide.

Type of Enrollment	Code	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Postal Premium</i>	<i>Postal Premium</i>
		<u>Biweekly</u>	<u>Biweekly</u>	<u>Monthly</u>	<u>Monthly</u>	<u>Biweekly</u>	<u>Biweekly</u>
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	3A1	\$132.66	\$44.22	\$287.43	\$95.81	\$156.98	\$19.90
High Option Self and Family	3A2	\$316.08	\$118.18	\$684.84	\$256.06	\$373.15	\$61.11
HDHP Self-Only	3A4	\$126.40	\$42.13	\$273.86	\$91.29	\$149.57	\$18.96
HDHP Self and Family	3A5	\$253.27	\$84.42	\$548.75	\$182.91	\$299.70	\$37.99