The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. Please read the FEHB Plan brochure (RI 73-699) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure at www.aultcare.com/fehb, and view the Glossary at www.aultcare.com/fehb. You can call 330-363-6360 or 1-800-344-8858 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Provider $2,000 / Self Only $4,000 / Self Plus One $4,000 / Self and Family Out-of-Network Provider $4,000 / Self Only $8,000 / Self Plus One $8,000 / Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Network preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network Provider $4,000 / Self $8,000 / Self Plus One $8,000 / Self and Family Out-of-Network Provider $8,000 / Self $16,000 / Self Plus One $16,000 / Self and Family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties, Prescription medication coupon, discount, or other manufacturer assistance programs for Specialty or other qualified medications (effective 04/01/2021), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aultcare.com or call 330-363-6360 or 1-800-344-8858 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No cost share	50% coinsurance	Deductible does not apply to well child care with an Out-of-Network Provider. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization required for certain radiology studies.

* For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-699 at www.aultcare.com/fehb.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aultcare.com/fehb.	Preventive Maintenance List	$0 copayment/prescription (not subject to the deductible)		Network deductible will apply to all drugs, except those on the Preventive Maintenance List. A 34-day supply is available at the retail pharmacy. A 90-day supply may be obtained through the mail order program. A 30-day supply of Specialty/Limited Distribution medications are fillable through AultCare's preferred specialty pharmacies only. Effective 04/01/2021, Prescription medication coupon, discount, or other manufacturer assistance programs for Specialty or other qualified medications will not apply toward your Deductible or Out-of-Pocket Maximum. If a prescription drug is purchased without using your card, AultCare will pay up to the allowed amount. Certain classes of medications require a Prior Authorization or Step Therapy. For a complete list of these medications please visit the AultCare website at www.aultcare.com.
	Generic drugs	20% coinsurance		
	Brand drugs	20% coinsurance		
	FreeStyle Libre (continuous glucose monitoring device)	20% coinsurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization required for certain surgical procedures.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	40% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Network deductible will apply. Preauthorization is required for non-emergent ambulance transportation.
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. A penalty up to $500 may apply for failure to obtain preauthorization.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-699 at www.aultcare.com/fehb.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on the corresponding medical benefit.	Benefits paid based on the corresponding medical benefit.	Services for Mental Health, Behavioral Health, or Substance Abuse are payable on the same basis as any other illness. Preauthorization is required for Partial Hospitalization and Intensive Outpatient programs.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. A penalty up to $500 may apply for failure to obtain preauthorization.
If you are pregnant	Office visits	Benefits paid based on the corresponding medical benefit.	Benefits paid based on the corresponding medical benefit.	Cost sharing does not apply to certain preventive services. Depending on the type of service, deductible or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Preauthorization is required. A penalty up to $500 may apply for failure to obtain preauthorization.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required. Coverage is limited to 60 visits per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Coverage for outpatient speech, physical, and occupational therapy is limited to 60 visits each per calendar year. Chiropractic manipulation therapy is limited to 24 visits per calendar year.
	Habilitation services	Benefits paid based on the corresponding medical benefit.	Benefits paid based on the corresponding medical benefit.	Coverage includes, but is not limited to, the diagnosis of Autism Spectrum Disorder. Services are limited to: Speech, Language, and Occupational Therapy – 60 visits per calendar year, Therapies for Applied Behavioral Analysis – 20 hours per week, and Mental/Behavioral Health Outpatient Services.
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required.

* For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-699 at www.aultcare.com/fehb.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required for any item greater than $2,500.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No cost share	50% coinsurance	Deductible does not apply to this benefit. Coverage is limited to eye exams through age 17.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic Surgery
- Dental Care
- Long-Term Care
- Routine Eye Care (adult)
- Non-emergency care when traveling outside the U.S.
- Routine foot care (except when under treatment for metabolic or peripheral vascular disease such as diabetes)
- Weight Loss Programs

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

- Acupuncture (if prescribed for lower back pain rehabilitation purposes)
- Bariatric Surgery
- Chiropractic Care
- Habilitative Services
- Hearing Aids
- Infertility Treatment
- Private Duty Nursing

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 330-363-6360 or 1-800-344-8858 or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: AultCare Customer Service Center at 330-363-6360 or 1-800-344-8858, or send your appeal in writing to our Grievance and Appeal Coordinator at P.O. Box 6029, Canton, Ohio 44706-0910.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

* For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-699 at www.aultcare.com/fehb.

Does this plan meet the Minimum Value Standards? **Yes**

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

Language Access Services:

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

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

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$2,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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

The plan's overall deductible	**$2,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$680
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,700**

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

The plan's overall deductible	**$2,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,160**

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