



AULTCARE

INDIVIDUAL & FAMILY
Health Benefit Plans for Northeast Ohio

Open Enrollment: November 1, 2023 - January 15, 2024.

You matter.

WHAT DOES AULTCARE OFFER?

As a leader in the healthcare industry for over 38 years, AultCare continues to keep members satisfied through innovative plan designs, superior customer service, and a cost-effective high quality network.



New plans offer:

- Guaranteed coverage / no pre-existing conditions
- Prescription drug benefits
- \$0 cost preventive care visits (in-network)
- \$0 cost flu shots (in-network)
- No forms to complete for claims (in-network)
- No lifetime dollar maximum limits on covered services



Coverage levels to meet your needs:

- Individual
- Individual and Spouse
- Individual and Child(ren)
- Entire Family



The following services are available 24/7 at www.aultcare.com:

- Access to your healthcare coverage, member ID cards, Explanation of Benefits, coverage details, claims, & more
- Prescription Plans & Formulary
- Physician's directory with search by name, location, or specialty

You can find information about non-covered benefits, practitioner and provider availability, utilization management procedures, pharmaceutical management procedures, and privacy rights at www.aultcare.com or 330-363-6360 (TTY: 711).

AULTCARE CUSTOMER SERVICE

Our strengths are at your service:

- REAL people answering the phone when you call
- Calls transferred, on average, in less than 30 seconds
- Local service: 330-363-6360 (TTY: 711)
- 24/7 Nurse hotline: 1-866-422-9603
- Email access: aultcare@aultcare.com
- In-person access at: 2600 Sixth Street S.W. Canton, Ohio 44710



AULTCARE continues to develop innovative products & plan designs to meet the needs of families & individuals.



AultCare's Marketplace plans are available in the highlighted counties.

AULTCARE

Helping you navigate the Marketplace



The 2024 Open Enrollment period begins November 1, 2023 and continues through January 15, 2024. A life-changing event may allow you to shop for health plans outside of the Open Enrollment period.

Life-changing events include:

- Marriage
- Birth of a child
- Moving into a new network
- Divorce
- Loss of insurance/job that provided insurance
- Aging out of parent's insurance (26 years of age)

AultCare offers many options in the following metal categories. Review our plans to see which fits your needs. Below is a quick look at the coverage:

Metal Plan	Average Health Plans Payment*
Bronze	60%
Silver	70%
Gold	80%

What factors affect your health plan costs?

- Age
- Family size
- Tobacco use
- Location
- Plan metal level

Dental & Vision options are available with some plans. Be sure to add those to your selections, if needed.



You've selected your plan, what does it include?

New AultCare health plans include:

- Prescription coverage
- Inpatient services
- Outpatient services
- Maternity coverage
- Newborn care services
- Pediatric services
- Emergency services
- In-network preventive care services such as screenings and physicals
- Ongoing Disease Management
- Urgent care services
- Laboratory services (blood work, screenings)
- Rehabilitation services
- Substance abuse services
- Mental health coverage
- Durable medical equipment services



The National Committee for Quality Assurance (NCQA) has awarded AultCare with NCQA Health Plan Accreditation for our Commercial PPO, Commercial HMO and Marketplace PPO products. NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.



These NCQA seals represent NCQA Health Plan report card year 2023-2024.

[AultCare Insurance Company Individual Marketing Brochure](#)

Enclosed is the Schedule of Benefits for this policy. This policy contains exclusions, limitations, reduction of benefits and certain terms under which the policy may be continued in force or discontinued. For costs and complete details of coverage, call or write your insurance agent or AultCare Insurance Company.

**Source: HealthCare.gov*

Zero Cost Share 2024 01January

Effective Date: 01/01/2024

ZERO COST SHARE

Company Name (also specify name for ID cards if different):

INDIVIDUAL (SELECT NETWORK): 6654 Plan -No Pediatric Dental / 6224 Plan – Pediatric Dental;

Group Number

W00005

Plan Design

PPO

Company Effective Date:

01/01/2014

What is the effective date of new plan or plan change ?:

01/01/2024

PERCENTILE TO PAY

Network Providers are paid based on AultCare's contracted rate (75th percentile). If different, please reflect in drop down.

Contracted Rate

Non Network Providers

Reference Based Pricing

Notes:

SELECT NETWORK PLAN AVAILABLE: NETWORK PROVIDERS CONSIST OF AULTMAN, AULTMAN ALLIANCE, AULTMAN ORRVILLE, UNION, TRINITY TWIN CITY, WOOSTER COMMUNITY AND AKRON CHILDREN'S HOSPITAL. ***** Dental - Network: DenteMax; 75th MDR (effective 1/1/16); (was 90th percentile prior to 1/1/16) // Federal No Surprise Act – Surprise Billing protections may apply.

All benefit limitations or maximums shall be considered on a paid basis unless specifically noted otherwise.

NEW COMPANY

Other?:

Not unless existing AultCare plan.

MISCELLANEOUS PLAN PROVISIONS

Do we follow AultCare's UM guidelines for this Company? If No, verify with Manager or Underwriting on an increased administrative fee.

Yes

Are there any unique plan provisions?:

NON GRANDFATHERED/HRSA

Notes:

Gender Dysphoria is covered. Please refer to the Gender Reassignment Surgery Medical Policy.

RUN IN (NEW GROUPS) RUN OUT (TERMED GROUPS)

Will AultCare administer run-in?

No

Will AultCare administer run-out?

No

ANCILLARY BENEFITS

DENTAL PLAN

Yes

What is the fee schedule percentile (see Definition) for the Dental plan?

See Note

Is deductible credit to be given for Dental?

No

Notes:

FEE SCHEDULE: NETWORK IS DENTEMAX; NON NETWORK IS 75th MDR (effective 1/1/16); (was 90th percentile prior to 1/1/16) *****Pediatric Dental is an OPTIONAL benefit. Confirm enrollee has chosen this as part of the plan thru benefit class codes. Services are covered to age 19 unless otherwise stated. - See Dental language in link for more information.

VISION PLAN	No
FLEXIBLE SPENDING ACCOUNT	No
LIMITED FLEXIBLE SPENDING ACCOUNT (HSA compatible)	No
LIFE	No
HEALTH REIMBURSEMENT ACCOUNT	No
SHORT TERM DISABILITY	No

MEDICAL BENEFITS

ABORTION

Is elective abortion covered? **No**

Standard: Medically necessary/Therapeutic is covered as allowed under applicable law, unless noted below.

Refer to Surgery for benefit level.

ACUPUNCTURE

Is acupuncture covered? No

Refer to Physical Therapy for benefit level unless otherwise noted.:

ALLERGY EXTRACT **100%** **100%³**

ALLERGY INJECTIONS

Office 100% 100%³

Outpatient 100% 100%³

Inpatient 100% 100%³

ALLERGY TESTING

Office 100% 100%³

Outpatient 100% 100%³

Inpatient 100% 100%³

Does this Benefit have any limitations? No

AMBULANCE

Benefit Level 100% 100%³

Should we consider billed charges when using non network provider? No

ANESTHESIA

Office 100% 100%³

Outpatient 100% 100%³

Inpatient 100% 100%³

ANNUAL PLAN MAXIMUM

What is the Annual Plan Maximum? UNLIMITED UNLIMITED

ARTIFICIAL INSEMINATION

Is artificial insemination covered? No

Refer to Infertility Services for benefit level.:

IN VITRO FERTILIZATION

Is in vitro fertilization covered? No

Refer to Infertility Services for benefit level.:

ASSISTANT SURGEON

Outpatient 100% 100%³

Inpatient 100% 100%³

ATTENTION DEFICIT DISORDER/ADHD THERAPY

Does this plan cover Attention Deficit Disorder/ADHD Therapy? Yes

If yes, coverage will be based on services rendered.

BIOFEEDBACK

Office NOT COVERED NOT COVERED

Outpatient NOT COVERED NOT COVERED

Inpatient NOT COVERED NOT COVERED

BIRTH CONTROL/INJECTIONS/AIDS

Does the Women's Preventive Services Act apply? If yes, all FDA approved Birth Control will be covered - see AultList for details. NOTE: Surgery-includes all related services. Yes

Benefit level 100% 100%³

Does this Benefit have any limitations? No

BREAST PROSTHESIS/BRA

UM Guideline: Covered based on the Women's Health and Cancer Act of 1998. First External Breast Prosthesis following surgery. If there is significant weight gain or loss, replacement would be approved by UM. Otherwise, one every 24 months.:

Plan allows 4 Post-Mastectomy Bras per calendar year, does plan design allow more? No

Refer to DME for Benefit Level.

CALENDAR OR PLAN YEAR?

Calendar Year

CARDIAC REHAB (Phase I, II, III)

Inpatient (Phase I) begins approximately 2-4 days following a heart attack, or 24 hours post-heart Surgery. Patients are assisted through range of motion exercises, which gradually progress to walking or stair climbing by the time of discharge. 100% 100%³

Outpatient (Phase II) is an outpatient, Hospital-based program, usually of 2-3 months duration. Patients engage in a monitored program of exercise therapy, health education and individualized or group support sessions. 100% 100%³

Phase III is an outpatient exercise program held at various community fitness facilities. Patients engage in conditioning activities supervised by a Registered Nurse and an exercise physiologist. This is not a covered service.:

Limitation Notes:

Outpatient is limited to 36 visits per calendar year.

CHEMO/RADIATION THERAPY

Office 100% 100%³

Outpatient 100% 100%³

Inpatient 100% 100%³

Does this Benefit have any limitations? No

CHIROPRACTIC SERVICES

Musculoskeletal (includes Vertebrae)? Yes

Vertebrae only? No

Maintenance care? No

Office Based on Service Based on Service

Limitation Note:

Specialist office visit benefit applies.

Manipulation Therapy		100%	100% ³
Diagnostic Services		Based on Service	Based on Service
Modality Services		Based on Service	Based on Service
Does this Benefit have any limitations?			Yes
Accumulation Type			Calendar Year
Manipulation Therapy	12		
Limitation Notes:			

Modalities are included with Physical Therapy and Occupational Therapy limitations.

CLAIM SUBMISSION TIME restriction (in months). **24**

COLONOSCOPY/SIGMOIDOSCOPY

Are routine Colonoscopy services covered? Yes

Does this benefit include sigmoidoscopy? (If No, routine will be considered under physical exam.) Yes

Does this include all Office or Outpatient related charges? Yes

Is this service included in the routine physical benefit? If yes, refer to Physical for benefit level. Yes

Does this Benefit have any limitations? No

COMMON ACCIDENT DEDUCTIBLE - If two or more family members are injured in the same accident, only one deductible will be taken for expenses related to that accident.

Does common accident deductible apply? No

COORDINATION OF BENEFITS

COB: When secondary payment combined with the primary carrier's payment, will not exceed the plan's allowed amount. We will never pay more than our normal liability would have been in the absence of other coverage. Yes

MANDATORY SPOUSAL POLICY: (if spouse has medical offered thru their employer they are required to take that coverage.) Is there a mandatory spousal policy? No

COPAYMENTS

Does this plan have office visit copayments? No

Are there other copayment amounts? No

NOTE: If "Network only" is used to designate copayment application, this will include any non-network benefit which pays the same as the network benefit (i.e. emergency care or urgent care).

Do all (medical/Rx) copayments apply to medical deductible? No

If no, do any specific copayments apply to the medical deductible? No

Do all (medical/Rx) copayments apply to medical out of pocket? No

If no, do any specific copayments apply to the medical out of pocket? No

DEDUCTIBLES

--- Individual Deductible None None

--- Family Deductible None None

Are deductibles based upon Calendar or Plan year? Calendar Year

Does the plan include last quarter carryover? No

Is there a separate deductible for a specific benefit? No

DENTAL/PEDIATRIC (Optional)

DENTAL/PEDIATRIC – This is optional. Confirm enrollee has chosen this as part of plan thru benefit class codes. Services are covered to age 19 unless otherwise stated.

– See Dental Language for more information

Benefit level 100% 100%³

- Periodic/Limited/Comprehensive /Comprehensive Periodontal Evaluations- 1 every 6 months.:
- Dental Intraoral-complete series- 1 every 60 months.
- Bitewings- single film, two films, four films, vertical (7-8 films); 1 set every 6 months.:
- Panoramic film- 1 every 60 months.
- Cephalometric Xray/Oral/Facial Photographic Images/Diagnostic Models:
- Prophylaxis- 1 every 6 months.
- Topical application of fluoride (excluding prophylaxis)- limited to 2 every 12 months.:
- Topical fluoride varnish - 2 in 12 months.
- Sealant - per tooth - unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 months :
- Preventive resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months. :
- Space maintainer – fixed – unilateral/bilateral/removable- unilateral/bilateral - Limited to children under age 19:
- Re-cementation of space maintainer - Limited to children under age 19

Benefit level 100% 100%³

- Orthodontia - Medically Necessary; services before 1/1/17 subject to a 24 month waiting period; services after 1/1/17 a waiting period does not apply.
- Palliative treatment of dental pain- minor procedure
- Amalgam 1 or more surfaces, primary or permanent
- Resin-based composite 1 or more surfaces, anterior
- Re-cement inlay and crowns
- Prefabricated stainless steel crown- primary tooth - Limited to 1 per tooth in 60 months:
- Prefabricated stainless steel crown- permanent tooth- Limited to 1 per tooth in 60 months:
- Protective Restoration/Pin Retention- per tooth, in addition to Restoration:
- Pulpal Therapy (resorbable filling)- anterior, primary tooth (excluding final restoration):
- Pulpal Therapy (resorbable filling)- posterior, primary tooth (excluding final restoration):
- Inlay/Onlay/Crown
- Root Canal

DENTAL SERVICES COVERED UNDER MEDICAL PLAN

Dental procedures covered under medical are services such as hospital charges if required to safeguard patient's health, oral surgery, (i.e. osseous surgery), removal of partial or full impactions, cysts or tumors, and accidental injury to teeth. :

Benefit levels are based on services rendered. Please indicate under NOTES if guidelines are different.:

Notes:

Dental services for accidental injury are limited to \$3,000 per episode for surgical treatment and anesthesia.

DIAGNOSTIC TESTING/LABORATORY/X-RAY

office	100%	100% ³
Outpatient	100%	100% ³
Inpatient	100%	100% ³
Does this Benefit have any limitations?		No

DIALYSIS

Office	100%	100% ³
Outpatient	100%	100% ³
Inpatient	100%	100% ³

DURABLE MEDICAL EQUIPMENT

UM Guidelines require prior authorization for any item greater than \$2,500.:

Benefit Level	100%	100% ³
Does this Benefit have any limitations?		No
Orthotics	100%	100% ³
Does this Benefit have any limitations?		No
Prosthetics		
Refer to DME for Benefit Level		
Does this Benefit have any limitations?		No
Are wigs covered?		Yes
Refer to DME for Benefit Level		
Does this Benefit have any limitations?		Yes
Limitation Notes:		

Wigs are only covered following cancer treatment.

Are diabetic supplies covered?		Yes
Diabetic Supplies	100%	100% ³
Does this Benefit have any limitations?		See Note
Limitation Notes:		

Diabetic services and admin fees provided by AllHealth are payable are 100% of the AllHealth contracted rate. Certain

Diabetic supplies are available through the Pharmacy Program with no cost share.

DIABETIC TRAINING - Refer to Training Manual

Is diabetic training covered?		Yes
Office	100%	100% ³
Outpatient	100%	100% ³
Inpatient	100%	100% ³

EDUCATION AND TRAINING - Refer to Training Manual

Is education and training covered?		Yes
Office	100%	100% ³
Outpatient	100%	100% ³
Inpatient	100%	100% ³

MEDICAL NUTRITION THERAPY - Refer to Training Manual

Is medical nutrition therapy covered?		Yes
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Office	100%	100% ³
Outpatient	100%	100% ³
Inpatient	100%	100% ³

Limitation Notes:

Additional Preventive services: Preventive Services Nutritional Counseling to prevent obesity in children and to prevent cardiovascular disease in adults with cardiovascular risk factors is limited to a total of 4 visits per benefit period.

EMERGENCY SERVICES

NON NETWORK PROVIDERS WILL BE PAID AT THE NETWORK LEVEL FOR EMERGENCY CARE SERVICES. (UCR WILL STILL APPLY TO NON NETWORK.)

Emergency Services -Emergency	100%	100% ³
Emergency Room Physician	100%	100% ³

EYE EXAM (ROUTINE)

Are routine eye exams covered under the medical plan?		Yes
Benefit level	100%	100% ³
Does this Benefit have any limitations?		Yes

Limitation Notes:

ROUTINE VISION CARE (PROFESSIONALLY INDICATED REFRACTION AND DILATION) IS ONLY COVERED TO AGE 19 *** NOT COVERED FOR ADULTS* ADDITIONAL BENEFIT LEVEL: Network: 100% no deductible; Non Network 100% UCR no deductible. // Additional Benefits include: 1 set of glasses per year ; 1 prescription of lenses per year (coverage includes: Single vision, or conventional bifocal, or trifocal, or lenticular lenses. Lenses may be glass, plastic, or polycarbonate with scratch resistant and/or ultraviolet protective coating.) In lieu of glasses, 1 prescription of contacts are covered, including fitting/evaluation/follow-up care.

GENE AND CELL THERAPY

Are Gene and Cell Therapy Services covered? If yes, benefits will be based on services rendered.		Yes
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Notes:

Gene and cell therapy is managed by Emerging Therapy Solutions.

GENETIC COUNSELING AND TESTING

Is genetic counseling and testing a covered service?		Yes
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UM Approval Required. Coverage will be paid based on services rendered.:

GYNECOLOGICAL EXAM (PAP TEST)

Are routine GYN Exams covered?		Yes
Benefit Level - Office Visit	100%	100% ³
Other Services - GYN	100%	100% ³
Does this Benefit have any limitations?		No
Are routine PAP Tests/Smears covered?		Yes
Benefit level	100%	100% ³
Does this Benefit have any limitations?		No

HABILITATIVE SERVICES

Benefit level	100%	100% ³
Services are mandated age 0 to age 21. This plan allows to what age?		No Limit
Speech/Language/Occupational Therapy limited to how many visits each per calendar year?		20
Therapies for Applied Behavioral Analysis are limited to how many hours per week?		20

Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans. :

HEARING (EXAM/AID)

Are Routine Hearing Exams covered? No
 Does this Benefit have any limitations? No
 Are Hearing Aid and/or Fittings covered? No
 Does this Benefit have any limitations? No

HOME HEALTH CARE

Benefit Level - UM Approval Required 100% 100%³
 Does this Benefit have any limitations? Yes
 Accumulation Type Calendar Year
 Visits 100

HOSPICE CARE

Benefit level (UM Approval Required) 100% 100%³
 Is Bereavement Counseling covered or not covered? Covered
 Does this Benefit have any limitations? No

IMMUNIZATIONS

Are Routine Immunizations past well child age limit covered? Yes
 Benefit level 100% 100%³
 Does this Benefit have any limitations? No

INFERTILITY MEDICATIONS

Are infertility drugs covered under prescription plan? If yes, refer to Pharmacy for details. Pharmacy Approval Required. No
 Are infertility drugs covered under medical plan? Pharmacy Approval Required. No
 Does this Benefit have any limitations? No

INFERTILITY TESTING

Is Infertility testing covered? Yes
 Office 100% 100%³
 Outpatient 100% 100%³
 Inpatient 100% 100%³

INFERTILITY TREATMENT

Is treatment of infertility covered? No

INJECTIONS (MEDICAL)

Office 100% 100%³
 Outpatient 100% 100%³
 Inpatient 100% 100%³
 Does this Benefit have any limitations? No

INPATIENT HOSPITAL

Ancillary Services (Hospital Related Charges)
 Benefit level 100% 100%³

INPATIENT PHYSICIAN SERVICES

Benefit level 100% 100%³
 Does this Benefit have any limitations? No

INPATIENT ROOM

Semi-Private	100%	100% ³
Is there a separate deductible per admission for inpatient?		No
Is there a separate copayment for inpatient admissions?		No
Does this Benefit have any limitations?		No

LIFETIME MAXIMUM

What is the Lifetime Maximum?	None	None
Is there an automatic reinstatement provision?		No

MAMMOGRAM (ROUTINE)

Are routine mammograms covered? (This benefit is for the actual routine mammogram. The office visit, depending on how billed, will pay under physical or GYN benefit.)

Benefit level	100%	100% ³
Does this Benefit have any limitations?		No

MASSOTHERAPY

Is Massotherapy covered when rendered by an LPT, DC, or MD? Yes

Are Massotherapists covered? No

Refer to Physical Therapy for benefit level.:

MATERNITY

Is coverage based on services rendered? Yes

ULTRASOUND (Routine Maternity)

UM guideline effective 1/1/2020 - Maternity Ultrasounds are covered as any other diagnostic service. (UM Guidelines prior to 2020: Ultrasounds on patients age 30 and over are permitted. • Routine ultrasounds for patients under 30 years of age are not covered. • Ultrasounds for medical reasons, other than routine, are eligible for all patients regardless of age.) :

Does this plan follow UM Guidelines Yes

Does this Benefit have any limitations? No

MATERNITY-DEPENDENT

Are maternity expenses (maternity and delivery charges for mother and baby) of a dependent child covered? Yes

For a dependent child's newborn expenses (charges after the initial delivery) to be covered, refer to Eligibility - Dependents for details:

MENTAL HEALTH, ALCOHOL AND/ OR SUBSTANCE ABUSE

Is medically necessary court ordered treatment covered? If covered, UM will review to determine medical necessity. Yes

Are mental health benefits carved out? No

Is there an Employee Assistance Program (EAP) available? No

Does the Mental Health Parity and Addiction Equity Act of 2008 apply to this plan?

NOTE: If yes, all mental health, alcohol and/or substance abuse claims are paid based upon services rendered. Yes

MHPA of 2008 Mental Health/Substance Abuse Inpatient Coverage will be paid the same as any other inpatient stay UNLESS NOTED BELOW. Refer to Inpatient Hospital for benefit level.

Limitation Notes:

Includes Residential Treatment Facilities.

MHPA of 2008 Mental Health/Substance Abuse Outpatient Treatment Program -In lieu of an inpatient stay (PHP or Partial Hospital Program) or Outpatient treatment (IOP or Intensive Outpatient Program) will be paid as any other outpatient service. 100%¹ 100%^{1,3}

MHPA of 2008 Mental Health/Substance Abuse Psychotherapy - Office Visit (same as PCP Office Visit): Refer to Physician Office for benefit level.

Limitation Notes:

The Mental Health Parity and Addiction Equity Act of 2008: Mental Health/Addiction Inpatient coverage will be paid the same as any other Inpatient stay. Refer to Inpatient Hospital for benefit level. Includes Residential Treatment facilities.

Mental Health/Substance Abuse Psychotherapy - Office Visit will be considered same as PCP office visit.

MHPA of 2008 Mental Health/Substance Abuse Psychological Testing: Refer to Diagnostic Services for benefit level.:

OBESITY

Is treatment of obesity a covered service? If covered, benefit level of services will be based on service rendered-refer to that section for details. UM Approval Required.:

	No
Are gastric restrictive procedures covered?	No
Does this Benefit have any limitations?	No

OCCUPATIONAL THERAPY (OT)

Injury or Illness related

Office	100%	100% ³
Outpatient	100%	100% ³
Inpatient	100%	100% ³

Does this Benefit have any limitations? Yes

Accumulation Type Calendar Year

Visits 40

Are limitations combined with speech therapy? No

Are limitations combined with physical therapy? Yes

Limitation Notes:

Outpatient and office Physical/Occupational therapy (including chiropractic modalities) is limited to 40 visits combined per calendar year.

OFFICE VISITS

PRIMARY CARE PHYSICIAN - Illness	100%	100% ³
PRIMARY CARE PHYSICIAN - Injury	100%	100% ³
SPECIALIST - Illness	100%	100% ³
PRIMARY CARE PHYSICIAN - Injury	100%	100% ³

Are OB/GYN visits paid as PCP? No

ORGAN DONOR

UTILIZATION MANAGEMENT APPROVAL REQUIRED.

Organ Donor	100%	100% ³
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COB with donor's coverage? If Yes, benefits will be coordinated with donor unless charges are included in global fee. Yes

Notes:

Gene and cell therapy is managed by Emerging Therapy Solutions.

Does this Benefit have any limitations? Yes

Accumulation Type Per Transplant

Dollars Maximum \$30,000

Limitation Notes:

Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure are covered under this Plan. The Unrelated donor search Benefit is limited to \$30,000 per Transplant Benefit period. Live Donor Health Services are also covered under this Plan unless donor Benefits are available to the donor from another source.

ORGAN TRANSPLANTS

UTILIZATION MANAGEMENT APPROVAL REQUIRED.

Organ transplants which are not experimental or investigational are covered.

What is the benefit level?	100%	100% ³
Does this Benefit have any limitations?		No
Does plan have a "separate" acquisition/transportation/lodging benefit for recipient and family?		Yes
If yes, at what benefit level:	100%	100% ³
Does this Benefit have any limitations?		Yes
Accumulation Type		Per Transplant
Dollars Maximum	\$10,000	

Limitation Notes:

Travel expenses includes transportation to and from the facility and lodging for the Patient and one companion, all charges will need to be reasonable, necessary, and itemized. The Transplant Transportation and Lodging benefit is limited to \$10,000 per Transplant Benefit period.

OUT-OF-POCKET

Individual Out of Pocket	None	None
Family Out of Pocket	None	None

Limitation Notes:

This plan follows the Marketplace Managed Formulary. // Prescription medication coupon, discount, or other manufacturer assistance programs for Specialty or other qualified medications will not apply to the Deductible or Out-of-Pocket Maximum.

Are the out of pocket amounts based upon calendar or plan year?	Calendar Year
Does the plan includes last quarter out of pocket carryover?	No

PAIN MANAGEMENT

Coverage based on service rendered.:

PHYSICAL EXAM

Are routine physical exams covered?		Yes
Benefit level - Office Visit	100%	100% ³
Other Services (i.e. preventive screenings)	100%	100% ³
Does this Benefit have any limitations?		Yes

Limitation Notes:

Covered Services for a routine physical include, but are not limited to, the Physician's office visit charge and related tests, x-rays, routine cancer screenings, routine mammograms, routine gynecological exam, routine pap, age and gender appropriate screening, routine prostate screening, lab work and immunizations. These Network services will be paid at 100% unless the routine physical is not defined as a Preventive Health Service.

PHYSICAL THERAPY (PT)

Injury or Illness related		
Office	100%	100% ³
Outpatient	100%	100% ³
Inpatient	100%	100% ³

Does this Benefit have any limitations?		Yes
Accumulation Type		Calendar Year
Visits	40	
Are limitations combined with speech therapy?		No
Are limitations combined with occupational therapy?		Yes

Limitation Notes:

Outpatient and office Physical/Occupational therapy (including chiropractic modalities) is limited to 40 visits combined per calendar year.

PODIATRY SERVICES

Office		Based on Service	Based on Service
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Limitation Notes:

Specialist office visit benefit applies.

Diagnostic Testing		Based on Service	Based on Service
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Copayment

Surgery-Office		Based on Service	Based on Service
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Surgery-Outpatient: See Outpatient Surgery

Other Podiatry Services		Based on Service	Based on Service
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Does this Benefit have any limitations?		No
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PRE-ADMISSION TESTING

Outpatient	100%	100% ³
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PRECERTIFICATION

Is precertification required for Network?		No
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Is precertification required for Non Network?		Yes
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If required, what is the precertification penalty?:

none

PRESCRIPTION DRUGS

The physician charges for the administration (injection/infusion) of a prescription purchased at a retail pharmacy or through mail order is covered under the medical plan.:

Medications dispensed in a physician's office are considered as other miscellaneous office services.:

Who is the drug program carrier?

PDM/Express Scripts/Optum RX - If yes see Aultshare pharmacy for details.:

Yes

Copays?:

No

HDHP/ Deductible applies first (Discount Card) Also complete section under medical plan:

Yes

Notes:

Managed Formulary 1/1/2021.

SaveonSP/OptumRX VCS? :

No

Notes::

Generic Incentive Program effective 1/1/2024.

Outside Vendor (i.e. Caremark, Express Scripts):

No

Will secondary drug charges be processed under the medical plan?		No	
Medical Plan:			Yes
Benefit level	100%		
Are any items (specialty drugs, injectable, infusions, etc.) not covered by the pharmacy plan covered under medical?		Yes	
Does this Benefit have any limitations?		No	
PRIVATE DUTY NURSING			
Benefit Level - UM Approval Required	100%	100% ³	
Does this Benefit have any limitations?		Yes	
Accumulation Type		Calendar Year	
Visits	90		
PROSTATE/PSA SCREENINGS			
Are routine Prostate/PSA screenings covered?		Yes	
Benefit level	100%	100% ³	
Does this Benefit have any limitations?		No	
RECONSTRUCTIVE SURGERY			
UM Approval Required. Refer to Surgery section for benefit. :			
REHABILITATION SERVICES			
Illness or Injury related			
Inpatient	100%	100% ³	
Does this Benefit have any limitations?		Yes	
Accumulation Type		Calendar Year	
Days	60		
Limitation Notes:			
Physical Rehabilitation Facilities include coverage for Day Rehab Program services subject to combined 60 day limit with inpatient services.			
RESPIRATORY THERAPY			
Office	100%	100% ³	
Outpatient	100%	100% ³	
Inpatient	100%	100% ³	
Limitation Notes:			
PULMONARY REHABILITATION: Limited to 20 visits per calendar year; When rendered in the home, Home Care Services limits apply. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.			
Includes outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.			
SECOND SURGICAL OPINION			
How is Second Surgical Opinion to be paid?	100%	100% ³	
Is second surgical required for Network?		No	
Is second surgical required for Non-Network?		No	
SKILLED NURSING FACILITY			
Benefit Level - UM Approval Required	100%	100% ³	
Does this Benefit have any limitations?		Yes	

Accumulation Type		Calendar Year
Days	90	

TOBACCO CESSATION (Medical Plan)

Are services covered under the medical plan? If no, refer to Pharmacy plan listing.		Yes
If yes, benefit level is	100%	100% ³
What services are covered under the medical plan?		
Hypnosis		Not Covered
Counseling		Covered
Drug Aids		See Rx
Does this Benefit have any limitations?		No

SPEECH THERAPY (ST)

Injury or Illness related		
Office	100%	100% ³
Outpatient	100%	100% ³
Inpatient	100%	100% ³
Does this Benefit have any limitations?		Yes
Accumulation Type		Calendar Year
Visits	20	
Are limitations combined with physical therapy?		No
Are limitations combined with occupational therapy?		No

Limitation Notes:

Outpatient and office speech therapy is limited to 20 visits combined per calendar year.

STERILIZATION

Does the Women's Preventive Services Act apply? If yes, if male refer to Surgery and if female refer to Birth Control for benefit levels.:

	Yes
Is reversal of sterilization covered?	Not Covered

SUBROGATION TYPE

Pay/Pursue	Yes
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SUPPLEMENTAL ACCIDENT

Does your plan include a Supplemental Accident provision?	No
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SURGERY SERVICES

Office	100%	100% ³
Outpatient	100%	100% ³
Does this plan have a Same Day Surgery Benefit?		No
Inpatient	100%	100% ³
Does this Benefit have any limitations?		No

TELEHEALTH/TELEMEDICINE

Telehealth refers to virtual services rendered by a provider, including behavioral health. Telemedicine refers to virtual services rendered by our preferred virtual vendor.

Is Telehealth covered?	Yes
Illness/Injury	Based on Service Based on Service
Is Telemedicine covered?	Yes
If yes, who is the vendor?	Aultman Now
Illness/Injury	100%
Is Telemedicine for Dermatology covered through the vendor?	Yes

Illness/Injury 100%

Does Telemedicine include Mental Health/Substance Abuse Psychotherapy services?
(If yes, refer to Mental Health/Substance Abuse Psychotherapy for coverage - same as PCP office visit). Yes

TEMPOROMANDIBULAR JOINT SYNDROME

Are services for Temporomandibular Joint Syndrome covered? Yes

Plan approval required Yes

Are benefits based on services rendered? Yes

Does this Benefit have any limitations? No

URGENT CARE FACILITY

NON NETWORK PROVIDERS WILL BE PAID AT THE NETWORK LEVEL FOR EMERGENT CARE SERVICES. (UCR WILL STILL APPLY TO NON NETWORK.)

Urgent Care Facility 100% 100%³

WELL CHILD CARE

Is well child care covered? Yes

Are immunizations included in well child care? Yes

Exam 100% 100%³

Other Services 100% 100%³

Does this Benefit have any limitations? Yes

Age limitation (through age) 20

Limitation Notes:

Services for Well Child Care include, but are not limited to, the Physician's office visit charge and related tests, lab work and immunizations. These Covered Network services will be paid at 100% unless the Well Child Care is not defined as a Preventive Health Service.

Is there a wellness dollar maximum? No

ELIGIBILITY

ELIGIBILITY (FOR INDIVIDUAL PLANS) -Is this plan offered to individuals? Yes

Effective Date: *****

Waiting Period: None.

Pre-Existing: Not Applicable.

Open Enrollment: Yes;

Late Applicants: Not Applicable.

Termination of Coverage: Coverage will terminate at end of month.

Common Law Recognized Prior To October 1, 1991: Yes.

Dependents Include: Spouse (Effective 01/01/2015 on renewal includes same sex spouse), natural children, adopted children or placed in anticipation of being adopted, children for whom you are the legal guardian, children for whom you have legal custody, QMSCO and step children.

Dependent Children Age Limit: State and Federal mandate applies; Coverage ends on: End of the billing cycle following their birthday.

Newborns/Immediate Coverage/Verification: *****

Divorce Decree Information/COB: when required

ELIGIBILITY (FOR SMALL GROUP PLANS) Is this plan offered to small groups? No

¹Covered Services are paid in accordance with Mental Health Parity and Addiction Equity Act of 2008, which prohibits discrimination in the coverage for diagnosis, care, and treatment of Mental Health and/or Substance Abuse.

²Preventive Health Services are the recommended preventive services required to be covered without cost sharing under federal law.

³Payments to Non-Network Providers for Covered Services are based on Reference Based Pricing criteria (RBP). Charges for Non-Network Provider Covered Services that exceed the RBP amount may be Your responsibility.

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