
 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. For more information about your coverage, or to get a copy of the complete terms of coverage, call AultCare at 330-363-6360 or go to www.aultcare.com. 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 view the Glossary at www.aultcas.com/aultcare/login.aspx or call 330-363-6360 or 1-800-344-8858 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | For network providers \$1,750 Individual / \$3,500 E + 1 / \$3,500 Family; For out-of-network providers \$3,500 Individual / \$7,000 E + 1 / \$7,000 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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 ? | For network providers \$3,500 Individual / \$7,000* E + 1 / \$7,000* Family For out-of-network providers \$7,000 Individual / \$14,000 E + 1 / \$14,000 Family | The out-of-pocket limit 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. *Maximum for an individual on an E+1 or Family plan is \$6,550. |
| What is not included in the out-of-pocket limit ? | Penalties, premiums , balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See www.aultcare.com 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 | 10% coinsurance | Illness: 20% coinsurance ; Injury: 10% coinsurance | Network deductible will apply to visits to an Out-of-Network provider for an injury. |
| | Specialist visit | 10% coinsurance | Illness: 20% coinsurance ; Injury: 10% coinsurance | Network deductible will apply to visits to an Out-of-Network provider for an injury. |
| | Preventive care/screening/immunization | No charge | Well child: 20% coinsurance All other preventive: Not Covered | Deductible does not apply. 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. Coverage for preventive care exams is limited to 1 each per calendar year. |
| If you have a test | Diagnostic test (x-ray, blood work) | 10% coinsurance | 20% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | | | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aultcare.com | Generic & Brand drugs | 10% coinsurance | | Network Deductible will apply. A 34-day supply is available at the Union Hospital Pharmacy. You may obtain a 90-day supply of your maintenance medications. The Union Hospital Pharmacy must fill your prescription for the exact quantity of medications prescribed by your doctor, up to the 90-day plan limit. "30 days plus 2 refills" does not equal one prescription written for "90 days". For prescriptions purchased outside of Union Hospital Pharmacy, members must manually submit prescription receipts for consideration. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 20% coinsurance | None |
| | Physician/surgeon fees | 10% coinsurance | 20% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | 10% coinsurance | 10% coinsurance | Network deductible will apply. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | Network deductible will apply. |
| | Urgent care | 10% coinsurance | 10% coinsurance | Network deductible will apply. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 20% coinsurance | Preauthorization is required. Penalty of \$500 may apply for failure to get preauthorization . |
| | Physician/surgeon fees | 10% coinsurance | 20% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 10% coinsurance | 20% coinsurance | None |
| | Inpatient services | 10% coinsurance | 20% coinsurance | Preauthorization is required. Penalty of \$500 may apply for failure to get preauthorization . |
| If you are pregnant | Office visits | 10% coinsurance | 20% coinsurance | None |
| | Childbirth/delivery professional services | 10% coinsurance | 20% coinsurance | None |
| | Childbirth/delivery facility services | 10% coinsurance | 20% coinsurance | Preauthorization is required. Penalty of \$500 may apply for failure to get preauthorization . |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | 20% coinsurance | Preauthorization is required. Coverage is limited to 60 visits per calendar year. |
| | Rehabilitation services | 10% coinsurance | 20% coinsurance | Must be illness/injury related. |
| | Habilitation services | Not covered | Not covered | None |
| | Skilled nursing care | 10% coinsurance | 20% coinsurance | Preauthorization is required. Coverage is limited to 50 days per illness. |
| | Durable medical equipment | 10% coinsurance | 20% coinsurance | Preauthorization is required for a single item with a purchase price over \$1,000. |
| | Hospice services | 10% coinsurance | 20% coinsurance | Preauthorization is required. |

| 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 your child needs dental or eye care | Eye Exam | No charge | 20% coinsurance | Coverage is provided for vision screening for all children between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors. |
| | Glasses | Not covered | Not covered | |
| | 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 (adult)
- Habilitation Services
- Hearing Aids
- Long Term Care
- Non-Emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture (Union Hospital only)
- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for group health coverage subject to ERISA, contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform; for non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: for group health coverage subject to ERISA, contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform or call the Ohio Department of Insurance 1-800-686-1526; for non-federal governmental group health plans and church plans that are group health plans, contact AultCare at 1-800-344-8858 or call the Ohio Department of Insurance 1-800-686-1526.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet 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 300-363-6360 / 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, kwijjigo 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 | \$1,750 |
| ■ Specialist coinsurance | 10% |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 10% |

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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,750 |
| Copayments | \$0 |
| Coinsurance | \$1,240 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$260 |
| The total Peg would pay is | \$3,250 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---------|
| ■ The plan's overall deductible | \$1,750 |
| ■ Specialist coinsurance | 10% |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 10% |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,750 |
| Copayments | \$0 |
| Coinsurance | \$720 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$2,530 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|---------|
| ■ The plan's overall deductible | \$1,750 |
| ■ Specialist coinsurance | 10% |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 10% |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,370 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,370 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Cushite-Oromo

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

Korean

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

Italian

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

Japanese

日本語
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Dutch

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

Ukrainian

український
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Romanian

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

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.