This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.aultcare.com or by calling 330-363-6360 or 1-800-344-8858.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network:** Ind: $300; E+1: $600; Fam: $600; **Non Network:** Ind: $500; E+1: $1,000; Fam: $1,000; Does not apply to office visits or preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Also, any expenses applied to an individual's **deductible**, in the last 3 months of a Calendar Year, will apply to that individual's **deductible** for the following Calendar Year.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes. For network providers:** Ind: $1,200; E+1: $2,400; Fam: $2,400; **For non-network providers:** Ind: $1,200; E+1: $2,400; Fam: $2,400;	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	**No.**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes.** For a list of network providers, see www.aultcare.com or call 330-363-6360 or 1-800-344-8858.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non network **provider** for some services. Plans use the term network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**No.**	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	**Yes.** Please refer to list of exclusions	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Integrated
Embedded Deductibles

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	$15/visit then 40% coinsurance	--none--
	Specialist visit	$15/visit	$15/visit then 40% coinsurance	--none--
	Other practitioner office visit	$15 per office visit and $5/visit then 20% coinsurance for other services for chiropractic and podiatry care	$15 per office visit then 40% coinsurance and $10/visit then 40% coinsurance for all other services for chiropractic and podiatry care	Coverage for chiropractic care is limited to 30 visits per calendar year.
	Preventive care/screening/immunization	No charge	Not covered; Well child care (to age 2): $15/visit then 40% coinsurance; Well child immunizations (to 19 months): 40% coinsurance;	--none--

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance Union Hospital only; additional $5/visit when performed at other network providers;	Inpatient: 40% coinsurance; Outpatient/office: $10/visit then 40% coinsurance;	--none--
	Imaging (CT/PET scans, MRIs)			--none--
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aultcare.com .	Brand/Generic Drugs	Cost of medication up to $70.00 = 20% co-insurance; Cost of medication over $70.00 = 30% co-insurance; Minimum charge of $5.00		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)	20% coinsurance	40% coinsurance	--none--
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--none--
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	Network deductible will apply.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Network deductible will apply.
	Urgent care	0% coinsurance	0% coinsurance	Network deductible will apply. Urgent Care provided by First Care in Union Hospital is payable after a $15/visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	A 50% penalty reduction of covered benefits may apply for failure to precertify.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	--none--

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office: $30/ visit; Outpatient: 20% coinsurance Union Hospital only; additional $5/visit when performed at other network providers;	$10/visit then 40% coinsurance;	--none--
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	A 50% penalty reduction of covered benefits may apply for failure to precertify.
	Substance use disorder outpatient services	Office: $30/ visit; Outpatient: 20% coinsurance Union Hospital only; additional $5/visit when performed at other network providers;	Office: $15/visit then 40% coinsurance; Outpatient: $10/visit then 40% coinsurance;	--none--
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	A 50% penalty reduction of covered benefits may apply for failure to precertify.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	--none--
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	A 50% penalty reduction of covered benefits may apply for failure to precertify.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Utilization Management approval required. Coverage is limited to 60 visits per calendar year.
	Rehabilitation services	Inpatient: 20% coinsurance; Office: $5/ visit then 20% coinsurance; Outpatient: 20% coinsurance Union Hospital only; additional $5/visit when performed at other network providers;	Inpatient:40% coinsurance; Outpatient/ Office: $10/visit then 40% coinsurance;	Must be illness/injury related.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	20% coinsurance	40% coinsurance	Utilization Management approval required. Coverage is limited to 50 days per illness.
	Durable medical equipment	20% coinsurance	50% coinsurance	Utilization Management approval required for a single item with a purchase price over $1,000.
	Hospice service	20% coinsurance	50% coinsurance	Utilization Management approval required.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam Medical Plan	No charge	40% coinsurance	Coverage is provided for vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.
	Vision Plan			Additional coverage is provided for children and adults. One complete refractory eye examination by ophthalmologists, optometrist, or optician is covered at 100% UCR after $15 copay once every 24 months. One set of prescribed lenses with the following maximum dollar allowances are provided for eyewear benefits once every 24 months: Single vision $35 Bifocal $55 Trifocal $85 Frames $55 Contact lenses $150 (in lieu of frames and lenses) **Lenses and Frames** or **Contacts** are payable once every 24 months, up to the above maximums.
	Glasses			
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Abortion (except in cases of rape, abortion, or when the life of the mother is endangered)
- Cosmetic Surgery
- Dental Care (adult)
- Hearing Aids
- Long Term Care
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (Union Hospital only)
- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Non-Emergency Care when traveling outside the U.S.
- Routine Eye Care (adult)
- Private Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, **contact the plan at 330-363-6360 or 1-800-344-8858.** You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: AultCare Customer Service Center at 330-363-6360 or 1-800-344-8858, or send your appeal or grievance in writing to our Grievance and Appeal Coordinator at P.O. Box 6029, Canton, Ohio 44706-0910, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,310
- **Patient pays** $1,230

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Co-pays	$0
Co-insurance	$900
Limits or exclusions	$30
Total	**$1,230**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,020
- **Patient pays** $1,380

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Co-pays	$100
Co-insurance	$900
Limits or exclusions	$80
Total	**$1,380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments, deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

AultCare/Aultra Notice Tag Lines for the State of Ohio

English
This Notice has Important Information. This notice has important information about your application or coverage through **AultCare /Aultra.** Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. **Call Local: 330.363.6360 Outside Stark County: 1.800.344.8858 TTY Local: 330.363.2393 Outside Stark County: 1.866.633.4752**

Spanish
Español
Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través **AultCare/Aultra.** Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al **Local : 330.363.6360 Fuera del condado de Stark : 1.800.344.8858 TTY Local : 330.363.2393 Fuera del condado de Stark : 1.866.633.4752**

Chinese
中文
本通知有重要的訊息。本通知有關於您透過 **AultCare/Aultra 保險公司** 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 本地： **330.363.6360 斯塔克縣外： 1.800.344.8858 TTY 線 本地： 330.363.2393 斯塔克縣外： 1.866.633.4752。**

German
Deutsche
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch **AultCare/Aultra**. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY –Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752.**

Arabic
ةيبرعلا يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال شركة التأمين AultCare/Aultra ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصور على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ 330.363.6360 خارج مقاطعة ستارك : 1.866.633.4752 خارج مقاطعة ستارك :TTY 1.800.344.8858

Pennsylvania Dutch
Pennsylvania Dutch
Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit **AultCare/Aultra**. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY – Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752.**

Russian
русский
Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через **Страховая компания AultCare/Aultra**. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону **Местный: 330.363.6360 Вне Старка County : 1.800.344.8858 TTY линия Местный: 330.363.2393 Вне Старка County : 1.866.633.4752.**

French
Français
Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de **Compagnie d'Assurance AultCare/Aultra**. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez **En dehors du comté de Stark : 1.800.344.8858 ligne ATS Local : 330.363.2393En dehors du comté de Stark : 1.866.633.4752**

Vietnamese
Việt Nam
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình **Công ty Bảo hiểm AultCare/Aultra**. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số **Địa phương: 330.363.6360 Bên ngoài của Stark County : 1.800.344.8858 TTY đường dây Địa phương: 330.363.2393 Bên ng oài của Stark County : 1.866.633.4752.**

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 dhumaa 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 회사계획** 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 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 카운티 의 외부 : 1.800.344.8858 TTY 라인 지역 : 330.363.2393 스타크 카운티 의 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
この通知には重要な情報が含まれています。この通知には **AultCare/Aultra** 保険会社 の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。**330.363.6360** スターク郡の外： **1.800.344.8858 TTY** ライン ローカル： **330.363.2393** スターク郡の外： **1.866.633.4752** までお電話ください。

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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