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, contact 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.aultcare.com 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 $2,000 Individual / $4,000 Family For out-of-network providers $4,000 Individual / $8,000 Family	Generally, you must pay all of the costs from providers up to the calendar year 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 and benefits that apply a copayment 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 $7,350 Individual / $14,700 Family For out-of-network providers $14,700 Individual/ $29,400 Family	The out-of-pocket limit is the most you could pay in a calendar 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.
What is not included in the out-of-pocket limit?	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 **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 copayment/visit	35% coinsurance	Deductible does not apply to office visits with a Network provider.
	Specialist visit	$40 copayment/visit	35% coinsurance	Deductible does not apply to office visits with a Network provider.
	Preventive care/screening/ immunization	No cost share	Routine eye and hearing exams - Not Covered Other preventive care - No cost share (see "Will you pay less if you use a 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	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aultcare.com	Generic drugs	**Retail Generic:** $7.50 copayment/prescription **Mail Order Generic:** $15 copayment/prescription		Deductible does not apply. A 30-day supply is available at the retail pharmacy for covered prescription drugs. A 90-day supply is available through the mail order program. Specialty/Limited Distribution drugs are limited to a 30-day supply. If a prescription drug is purchased without using your card, this Plan will pay up to the liability of the allowed amount. Maintenance medications are required to be filled through mail order. Certain preventive medications may be covered at 100%, with no cost to you. Also,
	Formulary/Preferred	**Retail Formulary/Preferred:** 25% coinsurance ($25 min / $100 max) **Diabetic Medications:** $30 copayment/prescription **Diabetic Supplies:** $0 copayment/prescription **Mail order Formulary/Preferred:** 25% coinsurance ($45 min / $200 max) **Diabetic Medications:** $60 copayment/prescription **Diabetic Supplies:** $0 copayment/prescription		

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)	
				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. Certain Generic Medications may be subject to an incentive which may reduce member cost share under the Generic Incentive Program.
	Non-Formulary/Non-Preferred	**Retail Non-Formulary/Non-Preferred:** Not covered **Diabetic Medications:** $45 copayment/prescription **Diabetic Supplies:** $0 copayment/prescription **Mail order Non-Formulary/Non-Preferred:** Not covered **Diabetic Medications:** $115 copayment/prescription **Diabetic Supplies:** $0 copayment/prescription		
	Specialty / Limited Distribution drugs ***Limited to a 30-day supply	**Retail or Mail order:** $100 copayment/prescription **Specialty/Limited Distribution drugs must be obtained from AultCare's Preferred Specialty Pharmacies.**		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	None
	Physician/surgeon fees	20% coinsurance	35% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copayment/visit	$150 copayment/visit	Deductible does not apply to this service. Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Network Deductible will apply.
	Urgent care	$40 copayment/visit	$40 copayment/visit	Deductible does not apply to this service.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment/ admission, then 20% coinsurance (after Network Deductible)	$290 copayment/ admission, then 35% coinsurance (after Out-of-Network Deductible)	Preauthorization is required. If admitted to a hospital more than once in a 60-day period, only one copayment will apply.
	Physician/surgeon fees	20% coinsurance	35% 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 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.
	Inpatient services	20% coinsurance	35% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Benefits paid based on the corresponding medical benefit.	Benefits paid based on the corresponding medical benefit.	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	35% coinsurance	None
	Childbirth/delivery facility services	$250 copayment/ admission, then 20% coinsurance	$290 copayment/ admission, then 35% coinsurance	Preauthorization is required. If admitted to a hospital more than once in a 60-day period, only one copayment will apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	35% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	35% coinsurance	Must be illness/injury related.
	Habilitation services	Benefits paid based on the corresponding medical benefit.	Benefits paid based on the corresponding medical benefit.	Coverage is limited to Autism Spectrum Disorder. Services are limited to the following: Speech/Language/Occupational Therapy – 20 visits per calendar year for each service; Clinical Therapeutic Intervention including ABA at 20 hours per week; and Mental/Behavioral Health Outpatient Services.
	Skilled nursing care	20% coinsurance	35% coinsurance	Preauthorization is required. Coverage is limited to 100 days per calendar year.
	Durable medical equipment	DME: 20% coinsurance; Diabetic Supplies: No cost share	DME and Diabetic Supplies: 35% coinsurance	Preauthorization is required for a single item with a purchase price over $2,500.

[* For more information about limitations and exceptions, see the plan or policy document at www.aultcare.com.]

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)	
	Hospice services	Inpatient: 0% coinsurance; Outpatient: 20% coinsurance	Inpatient or Outpatient: 20% coinsurance	Preauthorization is required. Network Deductible will apply.
If you or your child needs dental or eye care	Routine eye exam	No cost share	Not covered	Coverage limited to one exam per calendar year.
	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, as allowed under applicable law)
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Long Term Care
- Non-Emergency care when traveling outside the U.S.
- 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
- Bariatric Surgery
- Chiropractic Care
- Habilitative Services
- Infertility Treatment
- Private Duty Nursing
- Routine Eye Care

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, [* For more information about limitations and exceptions, see the plan or policy document at www.aultcare.com.]

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

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.

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.

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[* For more information about limitations and exceptions, see the plan or policy document at www.aultcare.com.]

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 copayment	**$40**
Hospital (facility) coinsurance	**$250/20%**
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	$260
Coinsurance	$2,060
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,380**

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 copayment	**$40**
Hospital (facility) coinsurance	**$250/20%**
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	$350
Copayments	$670
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,040**

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

The plan's overall deductible	**$2,000**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**$250/20%**
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	$1,840
Copayments	$240
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,080**

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