**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 or at www.MedMutual.com/SBC or by calling 1-800-540-2583.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | **Network:** Ind: $200 Fam: $400; Does not apply to office visits, hearing aid /exams, emergency care, routine physical exam, routine gynecological exam, or well child care. **Non Network:** Ind:$400 Fam: $800; Does not apply to office visit for injury, hearing aid/exams, or emergency 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 **deductible**, in the last 3 months of a Calendar Year, will apply to **deductible** for the following Calendar Year. |
| Are there other deductibles for specific services? | **Yes.** $25 annual deductible for prescriptions. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| Is there an out–of–pocket limit on my expenses? | **Yes. For network providers:** ind: $1,500 Fam: $3,000 **For non-network providers:** Ind: $3,000 Fam: $6,000 | 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. (See below.) |
| What is not included in the out–of–pocket limit? | Deductibles, copayments, 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 Annual Limit on payment for essential health benefits.** | However, the chart starting on page 2 describes *specific* coverage limits, such as limits on the number of 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 or www.medmutual.com or call 1-800-540-2583. | 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 exclusion | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

**Questions:** For Aultcare participants, call **330-363-6360** or **1-800-344-8858** or visit **www.aultcare.com**. For Medical Mutual participants, call 1-800-540-2583 or visit www.MedMutual.com/SBC.



If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.aultcare.com** or call 330-363-6360 or 1-800-344-8858 or at www.MedMutual.com/SBC or call 1-800-540-2583 to request a copy.

- **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 | $20/visit then 15% coinsurance illness/15% coinsurance injury | 35% coinsurance | After deductible for non-network. |
| | Specialist visit | $20/visit then 15% coinsurance illness/15% coinsurance injury | 35% coinsurance | After deductible for non-network. |
| | Other practitioner office visit | $20/visit then 15% coinsurance for office visits for chiropractic or podiatry care; All other chiropractic services 20% coinsurance and 15% coinsurance for all other podiatry care | 35% coinsurance for chiropractic and podiatry care | After deductible for non-network. |

| 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 |
|---|---|---|---|---|
| | Preventive care/screening/immunization | $20/visit then 15% for Routine physical exams, Routine gynecological exams and well-baby/child care; 15% coinsurance for all other routine services; | 35% coinsurance | After deductible for non-network. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 15% coinsurance | 35% coinsurance | After deductible. |
| | Imaging (CT/PET scans, MRIs) | 15% coinsurance | 35% coinsurance | After deductible. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.saverx.com . | Generic drugs | Retail or Mail order: 10% of billed amount subject to $5 minimum copay | | A $25 deductible applies. A 34 day supply is available at the retail pharmacy. A 90 day supply may be obtained through the mail order program. **Brand with Generic available:** If you or your physician request that a brand medication be dispensed, you will be responsible for the difference between the maximum allowable cost of the generic and the brand drug. |
| | Brand drugs | Retail or Mail order: 20% of billed amount subject to $10 minimum copay | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | 35% coinsurance | After deductible. |
| | Physician/surgeon fees | 15% coinsurance | 35% coinsurance | After deductible. |
| **If you need immediate medical attention** | Emergency room services | 15% coinsurance | 15% coinsurance | Coinsurance will apply to network out of pocket. |
| | Emergency medical transportation | 15% coinsurance | 15% coinsurance | After deductible. |

| 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 |
|---|---|---|---|---|
| | Urgent care | $20 for visit, then additional services at visit, such as x-rays or other diagnostic test, 15% co-insurance. | 35% coinsurance | After deductible (non-network only). Coinsurance will apply to network out of pocket. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance | 35% coinsurance | After deductible. Precertification is recommended. |
| | Physician/surgeon fee | 15% coinsurance | 35% coinsurance | After deductible. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 15% coinsurance | 35% coinsurance | After deductible. |
| | Mental/Behavioral health inpatient services | 15% coinsurance | 35% coinsurance | After deductible. |
| | Substance use disorder outpatient services | 15% coinsurance | 35% coinsurance | After deductible |
| | Substance use disorder inpatient services | 15% coinsurance | 35% coinsurance | After deductible. |
| **If you are pregnant** | Prenatal and postnatal care | 15% coinsurance | 35% coinsurance | After deductible. Precertification is recommended. Maternity care and services not provided for dependent children. |
| | Delivery and all inpatient services | 15% coinsurance | 35% coinsurance | After deductible. Precertification is recommended. Maternity care and services not provided for dependent children. |

| 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 need help recovering or have other special health needs** | Home health care | 15% coinsurance | 35% coinsurance | After deductible. |
| | Rehabilitation/Habilitation services (Physical therapy) | 20% coinsurance at physician, 15% coinsurance at facility. | 40% coinsurance at physician, 35% coinsurance at facility. | After deductible. |
| | Skilled nursing care | 15% coinsurance | 35% coinsurance | After deductible. |
| | Durable medical equipment | 15% coinsurance | 35% coinsurance | After deductible. |
| | Hospice service | 15% coinsurance | 35% coinsurance | After deductible. |
| **If your child needs dental or eye care** | Eye exam | Covered | Covered | Exams are limited to 1 per person per calendar year. Lenses are limited to 1 set per calendar year. Frames are limited to once every 2 years per person. |
| | Glasses | Not Covered | Not Covered | |
| | Dental check-up | 20% coinsurance | 20% coinsurance | Subject to UCR. |

## 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.)**

- Acupuncture
- Cosmetic Surgery
- Infertility Treatment
- Long Term Care
- Maternity Care for Dependent Children
- Routine Foot Care

**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.)**

- Bariatric Surgery
- Chiropractic Care
- Dental Care (adult)
- Hearing Aids
- Non-Emergency Care when traveling outside the U.S
- Private Duty Nursing
- Routine Eye Care (adult)

## 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.

## 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 does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This plan does meet the minimum standard for the benefits it provides.**

## 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: For Aultcare participants, contact AultCare Customer Service Center at 330-363-6360 or 1-800-344-8858. For Medical Mutual participants, contact 1-800-540-2583. Or, you can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

## 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** $6,120
- **Patient pays** $1,420

**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 | $200 |
| Co-pays | $10 |
| Co-insurance | $1,060 |
| Limits or exclusions | $150 |
| **Total** | **$1,420** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,140
- **Patient pays** $1,260

**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 | $200 |
| Co-pays | $430 |
| Co-insurance | $250 |
| Limits or exclusions | $80 |
| **Total** | **$1,080** |

# 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 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.