




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 1-800-344-8858 / [www.aultcare.com](http://www.aultcare.com) or Medical Mutual at 1-800-228-6472 / [www.medmutual.com](http://www.medmutual.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](http://www.aultcare.com), [www.medmutual.com](http://www.medmutual.com), or by calling AultCare 1-800-344-8848 or Medical Mutual 1-800-228-6472 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> \$300 Individual / \$600 Family For <a href="#">out-of-network providers</a> \$600 Individual / \$1,200 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the calendar year <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Network preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$1,200 Individual / \$2,400 Family For <a href="#">out-of-network providers</a> \$2,400 Individual/ \$4,800 Family  <a href="#">Network and out-of-network, non-emergency care</a> will track toward a separate <a href="#">out-of-pocket limit</a> , not to exceed \$7,900 Individual/ \$15,800 Family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a calendar year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Penalties</a> , <a href="#">Premiums</a> , <a href="#">balance-billing charges</a> , Prescription medication coupon, discount, or other manufacturer assistance programs for Specialty or other qualified medications, and health	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
	care this plan doesn't cover.	
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of <a href="#">network providers</a> : AultCare: see <a href="http://www.aultcare.com">www.aultcare.com</a> or call 1-800-344-8858; Medical Mutual: see <a href="http://www.medmutual.com">www.medmutual.com</a> or call 1-800-228-6472.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your provider if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. Coverage for routine physicals, routine mammograms, prostate screening or pap test is limited to one per calendar year. Routine gynecological exams are limited to two per calendar year.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required for certain imaging services.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.aultcare.com](http://www.aultcare.com) or [www.medmutual.com](http://www.medmutual.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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> or contact a Customer Care Representative at 1-888-202-1654.</p>	Generic drugs / Brand drugs	20% <a href="#">coinsurance</a>	Not covered	<p>Mandatory generic drugs where available (unless doctor specifies Dispense as Written). Mail order is required for long term prescription drugs, limited to first fill and one refill at retail pharmacy. All subsequent prescription drugs must be filled by mail.</p> <p><b>Prescription medication coupon, discount, or other manufacturer assistance programs for Specialty or other qualified medications will not apply toward your <a href="#">Deductible</a> or <a href="#">Out-of-Pocket Maximum</a>.</b></p>
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required for certain surgery services.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> will apply.
	<a href="#">Non-Emergency room care</a>	\$175 <a href="#">copayment</a> , then 10% <a href="#">coinsurance</a>	\$175 <a href="#">copayment</a> , then 20% <a href="#">coinsurance</a>	<a href="#">Network &amp; Non-Network deductible</a> will not apply. <a href="#">Copayment</a> and <a href="#">coinsurance</a> , not to exceed <a href="#">out-of-pocket limit</a> of \$7,900 Individual/\$15,800 Family.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> will apply.
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Penalty of \$200 may apply for failure to obtain <a href="#">preauthorization</a> .
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
<p><b>If you need mental health, behavioral health, or substance</b></p>	Outpatient services	Benefits based upon the corresponding medical benefit.	Benefits based upon the corresponding medical benefit.	Services for Mental Health, Behavioral Health, or Substance Abuse are payable on the same basis as any other illness.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.aultcare.com](http://www.aultcare.com) or [www.medmutual.com](http://www.medmutual.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)	
<b>abuse services</b>	Inpatient services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Penalty of \$200 may apply for failure to obtain <a href="#">preauthorization</a> .
<b>If you are pregnant</b>	Office visits	Benefits based upon the corresponding medical benefit.	Benefits based upon the corresponding medical benefit.	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of service, <a href="#">deductible</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Penalty of \$200 may apply for failure to obtain <a href="#">preauthorization</a> .
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required for ongoing services.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required for ongoing services.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for certain DME services.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	20% <a href="#">coinsurance</a>	Eye exam coverage through age 20.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Abortion (except in cases of rape, incest, or when the life of the mother is endangered, as allowed under applicable law)</li> <li>Acupuncture</li> <li>Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (adult)</li> <li>Hearing Aids</li> <li>Long Term Care</li> </ul>	<ul style="list-style-type: none"> <li>Non-Emergency care when traveling outside the U.S.</li> <li>Routine Eye Care (adult)</li> <li>Routine Foot Care</li> </ul>

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**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- Cosmetic Surgery
- Weight Loss Programs

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

- Chiropractic Care
- Infertility Treatment
- Private Duty Nursing
- Habilitation Services

**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](http://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](http://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](http://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](http://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, Medical Mutual at 1-800-228-6472, 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 AultCare 1-800-344-8858, Medical Mutual 1-800-228-6472.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa AultCare 1-800-344-8858, Medical Mutual 1-800-228-6472.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 AultCare 1-800-344-8858, Medical Mutual 1-800-228-6472.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' AultCare 1-800-344-8858, Medical Mutual 1-800-228-6472.]

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control

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number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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](#) \$300
- [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,260</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$300
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$820</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$300
- [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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>

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