**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

**Coverage Period: Beginning on or after 01/01/2024**

AULTCARE : Silver Premier Standard Select No Pediatric Dental CSR-73

**Coverage for:** Individual/Family **Plan Type:** PPO

**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<br>$5,700 Individual / $11,400 Family<br>For out-of-network providers<br>$17,100 Individual /$34,200 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<br>$7,200 Individual / $14,400 Family<br>For out-of-network providers<br>$28,350 Individual/ $56,700 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, prescription drug coupon, discount or assistance programs, 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** | No. | You can see the specialist you choose without a referral. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **see a specialist?** | | |

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 | $40 copayment | 60% coinsurance | Deductible does not apply to office visits with a Network provider. |
| | Specialist visit | $80 copayment | 60% coinsurance | |
| | Preventive care/screening/ immunization | No charge | 60% coinsurance | 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) | 40% coinsurance | 60% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | 60% coinsurance | None |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.aultcare.com<br><br>This plan follows the Marketplace Managed Formulary. | Generic drugs<br>(Tier 2 - Preferred Generic drugs) | **Retail:** $20 copayment<br>**Mail order:** $20 copayment | **Retail:** $20 copayment<br>**Mail order:** $20 copayment | Network Deductible applies to tiers 4 through 6. Tier 1 Preventive drugs may be covered at 100%, with no cost to you.<br><br>A 34-day supply is available at the retail pharmacy for generic and brand name prescription drugs. You may obtain up to a 60-day supply of Tier 1 and Tier 2 prescription drugs at the retail pharmacy for the mail order amount. A 90-day supply of Preventive/Generic/Brand drugs are available through the mail order program. Specialty drugs are limited to a 30-day fill and must be obtained from AultCare's Preferred Specialty Pharmacies. |
| | Preferred Brand drugs<br>(Tier 3 - Non-Preferred Generic / Preferred Brand drugs) | **Retail:** $40 copayment<br>**Mail order:** $40 copayment | **Retail:** $40 copayment<br>**Mail order:** $40 copayment | |
| | Non-Preferred Brand drugs<br>(Tier 4 - Non-Preferred Generic / | **Retail:** $80 copayment (after Network Deductible); | **Retail:** $80 copayment (after Network Deductible); | |

[* 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) | |
| | Non-Preferred Brand drugs) | **Mail order:** $80 copayment (after Network Deductible) | **Mail order:** $80 copayment (after Network Deductible) | Certain Generic Medications may be subject to an incentive which may reduce member cost share under the Generic Incentive Program.<br><br>If a prescription is purchased without using your card, the plan will pay up to the allowed amount. **Certain prescription drug coupon, discount, or assistance programs will not apply toward your Deductible or Out-of-Pocket Maximum.** 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. |
| | Specialty drugs (Tier 5 and 6 – Preferred Generic Specialty and Preferred Brand Specialty) | $350 copayment (after Network Deductible) | $350 copayment (after Network Deductible) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance | 60% coinsurance | None |
| | Physician/surgeon fees | 40% coinsurance | 60% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 40% coinsurance | 40% coinsurance | Network deductible will apply. |
| | Emergency medical transportation | 40% coinsurance | 40% coinsurance | Network deductible will apply. |
| | Urgent care | $60 copayment | $60 copayment | Deductible does not apply to this service. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% coinsurance | 60% coinsurance | Preauthorization is recommended. |
| | Physician/surgeon fees | 40% coinsurance | 60% coinsurance | None |
| **If you need mental health, behavioral** | Outpatient services | $40 copayment | 60% coinsurance | Services for Mental Health, Behavioral Health, or Substance Abuse are payable on |

| 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) | |
| **health, or substance abuse services** | | | | the same basis as any other illness. |
| | Inpatient services | 40% coinsurance | 60% coinsurance | Preauthorization is recommended. |
| **If you are pregnant** | Office visits | 40% coinsurance | 60% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of service, a copayment, deductible, or coinsurance may apply. |
| | Childbirth/delivery professional services | 40% coinsurance | 60% coinsurance | None |
| | Childbirth/delivery facility services | 40% coinsurance | 60% coinsurance | Preauthorization is recommended. |
| **If you need help recovering or have other special health needs** | Home health care | 40% coinsurance | 60% coinsurance | Preauthorization is recommended. Coverage is limited to 100 visits per calendar year. |
| | Rehabilitation services | $40 copayment | 60% coinsurance | Must be illness/injury related. Coverage for outpatient cardiac rehabilitation is limited to 36 visits per calendar year. Outpatient speech therapy is limited to 20 visits per calendar year; outpatient occupational and physical therapy is limited to 40 visits combined per calendar year. Manipulation therapy is limited to 12 treatments per calendar year. |
| | Habilitation services | 40% coinsurance | 60% coinsurance | Coverage includes, but is not limited to Autism Spectrum Disorder. Services are limited to the following: Speech/Language/Occupational Therapy - 20 visits per calendar year for each service; and Clinical Therapeutic Intervention including ABA at 20 hours per week; and Mental/ Behavioral Health Outpatient Services. |

| 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) | |
| | Skilled nursing care | 40% coinsurance | 60% coinsurance | Preauthorization is recommended. Coverage is limited to 90 days per calendar year. |
| | Durable medical equipment | 40% coinsurance | 60% coinsurance | Preauthorization is recommended for a single item with a purchase price over $2,500. |
| | Hospice services | 40% coinsurance | 60% coinsurance | Preauthorization is recommended. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | 60% coinsurance | Coverage limited to one visit/year to age 19. |
| | Children's glasses | 40% coinsurance | 60% coinsurance | Coverage limited to standard frames and lenses up to one pair per calendar year. In lieu of glasses, contacts are covered and limited to 1 prescription/calendar year to age 19. |
| | Children's 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)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-Emergency care when traveling outside the U.S.
- 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.)**

- Chiropractic Care
- Habilitation Services
- Private Duty Nursing

**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**

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?** **Not Applicable**

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** | **$5,700** |
| **Specialist copayment** | **$80** |
| **Hospital (facility) coinsurance** | **40%** |
| **Other coinsurance** | **40%** |

**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 | $5,700 |
| Copayments | $0 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,260** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$5,700** |
| **Specialist copayment** | **$80** |
| **Hospital (facility) coinsurance** | **40%** |
| **Other coinsurance** | **40%** |

**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 | $900 |
| Copayments | $1,100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,020** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$5,700** |
| **Specialist copayment** | **$80** |
| **Hospital (facility) coinsurance** | **40%** |
| **Other coinsurance** | **40%** |

**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 | $2,500 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,700** |

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