



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 1-888-404-0335 / [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 1-888-404-0335 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                             | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | For <a href="#">network providers</a><br>\$350 Individual / \$700 Family<br>For <a href="#">out-of-network providers</a><br>\$700 Individual / \$1,400 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> .                                                                                                                                        |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | 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> . |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.                                                                                                                                                                                                                                                                                                                                                                                                                                                 | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | For <a href="#">network providers</a><br>\$1,400 Individual / \$2,800 Family<br>For <a href="#">out-of-network providers</a><br>\$2,800 Individual/ \$5,600 Family<br><br>Non-emergent Emergency Room <a href="#">copayment</a> and <a href="#">coinsurance</a> tracks toward a separate <a href="#">out-of-pocket maximum</a> , not to exceed: Network: \$7,700 Individual / \$15,400 Family // Non-Network: \$7,500 Individual / \$15,000 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.                                                                                                                                                                                                                                                                              |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <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                                                                                                                                                                                                                                         | 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:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                    | qualified medications, and health care this plan doesn't cover.                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>            | 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 1-888-404-0335. | 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. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b> | 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                                                        | 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. |
| <b>If you have a test</b>                                                                                                                                                                                                                                            | <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.                                                                                                                                                                                                                                                                                                                        |
| <b>If you need drugs to treat your illness or condition</b><br>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. | Generic drugs                                          | 20% <a href="#">coinsurance</a>              | Not covered                                        | Mandatory generic drugs where available (unless doctor specifies Dispense as Written). Maintenance drugs may be filled at a retail pharmacy up to two times, then mail order is required.                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                      | Preferred brand drugs                                  | 20% <a href="#">coinsurance</a>              | Not covered                                        | Specialty medications which are eligible through PrudentRX Solution will have no cost share to the member. 30% coinsurance will apply if member does not participate in PrudentRX Solution for eligible specialty medications. Review the Prudent RX Program Drug List at <a href="http://www.caremark.com">www.caremark.com</a> .                                                                    |
|                                                                                                                                                                                                                                                                      | Non-Preferred brand drugs                              | 30% <a href="#">coinsurance</a>              | Not covered                                        | Prescription medication coupon, discount, or other manufacturer assistance programs for                                                                                                                                                                                                                                                                                                               |

[\* 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<br>(You will pay the least)                           | Out-of-Network Provider<br>(You will pay the most)                     |                                                                                                                                                                                                                                                                                                                                         |
|                                                                           | Specialty drugs                                         | 20% <a href="#">coinsurance</a>                                        | Not covered                                                            | Specialty or other qualified medications will not apply toward your <a href="#">Deductible</a> or <a href="#">Out-of-Pocket Maximum</a> .                                                                                                                                                                                               |
| If you have outpatient surgery                                            | 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                                                                                                                                                                                                                                                                                                                                    |
| If you need immediate medical attention                                   | <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 care</a> in an Emergency room | \$250 <a href="#">copayment</a> , then 10% <a href="#">coinsurance</a> | \$250 <a href="#">copayment</a> , then 20% <a href="#">coinsurance</a> | <a href="#">Network &amp; Non-Network deductible</a> will not apply. The emergency room facility charge will apply <a href="#">copayment</a> and <a href="#">coinsurance</a> , not to exceed <a href="#">out-of-pocket limit</a> of Network: \$7,700 Individual / \$15,400 Family // Non-Network: \$7,500 Individual / \$15,000 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                                                                                                                                                                                                                                                                                                                                    |
| If you have a hospital stay                                               | 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                                                                                                                                                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | 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.                                                                                                                                                                                                                   |
|                                                                           | 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> .                                                                                                                                                                                                       |
| If you are pregnant                                                       | 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                                                        |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                            |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                   |
|                                                                |                                           |                                              |                                                    | (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> . |
| If you need help recovering or have other special health needs | <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.                                                                                     |
| If your child needs dental or eye care                         | 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> </ul>  | <ul style="list-style-type: none"> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> <li>Dental Care (adult)</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> <li>Weight Loss Programs</li> </ul> |  |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                      |                                                                                                                                                                      |                                                                                                                                                                                                 |  |
| <ul style="list-style-type: none"> <li>Chiropractic Care</li> <li>Habilitation Services</li> </ul>                                                                                                | <ul style="list-style-type: none"> <li>Hearing aids are covered in Network at 100%, up to a maximum of \$2,500 per ear once every 4 years through age 21.</li> </ul> | <ul style="list-style-type: none"> <li>Infertility Treatment</li> <li>Private Duty Nursing</li> </ul>                                                                                           |  |

**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. Pennsylvania Dutch (Deutsch): Fer Hilf griegie In Deutsch, ruf 330-363-6360 uff.

**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 1-888-404-0335, or call the Ohio Department of Insurance 1-800-686-1526. Pennsylvania Dutch (Deutsch): Fer Hilf griegie In Deutsch, ruf 330-363-6360 uff.

**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:**

[Pennsylvania Dutch (Deutsch): Fer Hilf griegie In Deutsch, ruf 330-363-6360 uff.]

[Spanish (Español): Para obtener asistencia en Español, llame al AultCare 1-800-344-8858, Medical Mutual 1-888-404-0335.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa AultCare 1-800-344-8858, Medical Mutual 1-888-404-0335.]

[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 1-888-404-0335.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' AultCare 1-800-344-8858, Medical Mutual 1-888-404-0335.]

*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 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$350 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%   |
| ■ Other <a href="#">coinsurance</a>                             | 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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$350   |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$1,100 |

| What isn't covered   |      |
|----------------------|------|
| Limits or exclusions | \$60 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$1,510</b> |
|-----------------------------------|----------------|

### Managing Joe's Type 2 Diabetes

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$350 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%   |
| ■ Other <a href="#">coinsurance</a>                             | 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> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$350 |
| <a href="#">Copayments</a>  | \$0   |
| <a href="#">Coinsurance</a> | \$500 |

| What isn't covered   |      |
|----------------------|------|
| Limits or exclusions | \$20 |

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Joe would pay is</b> | <b>\$870</b> |
|-----------------------------------|--------------|

### Mia's Simple Fracture

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$350 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%   |
| ■ Other <a href="#">coinsurance</a>                             | 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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$350 |
| <a href="#">Copayments</a>  | \$0   |
| <a href="#">Coinsurance</a> | \$300 |

| What isn't covered   |     |
|----------------------|-----|
| Limits or exclusions | \$0 |

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Mia would pay is</b> | <b>\$650</b> |
|-----------------------------------|--------------|

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

## 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: 711 Outside Stark County: 711**

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### 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 : 711 Fuera del condado de Stark : 711**

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### 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：711 斯塔克縣外：711。

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### 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: 711 Außerhalb von Stark County : 711**

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### Arabic

العربية

يحتوي هذا الإشعار معلومات هامة. يحتوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلا شركة التأمين AultCare/Aultra. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ 330.363.6360 خارج مقاطعة ستارك: 1.800.344.8858 لخط TTY المحلي: 711 خارج مقاطعة ستارك: 711

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### Pennsylvania Dutch

Deitsch

Die Bekanntmachung gebt wichdichi Auskunft. Die Bekanntmachung 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 beschtimnde 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 grieghe, un die Hilf koschtet nix **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY – Linie Local: 711 Außerhalb von Stark County : 711.**

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### 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: 711 Вне Старка County : 711.**

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### 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 Locale: 330.363.6360 En dehors du comté de Stark : 1.800.344.8858 ligne ATS Local : 711 En dehors du comté de Stark : 711**

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### 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 giúp 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: 711 Bên ngoài của Stark County : 711.**

## 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 dhuma 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: 711 Outside of Stark County: 711** tii bilbilaa.

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## Korean

한국어  
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 **AultCare/Aultra** 보험 회사계획을 통한 커버리지에 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 카운티의 외부 : 1.800.344.8858 TTY 라인 지역 : 711 스타크 카운티의 외부 : 711** 로 전화하십시오.

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## 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: 711 Al di fuori di Stark County : 711**.

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## 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ぬ場合があります。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 : 711 スターク郡の外 : 711** までお電話ください。

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## 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 : 711 Buiten Stark County : 711**.

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## Ukrainian

український  
Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через **Страхова компанія AultCare/Aultra**. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону **Місцевий : 330.363.6360 Поза Старка County : 1.800.344.8858 TTY лінія Місцевий : 711 Поза Старка County : 711**.

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## Romanian

Română  
Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin **Compania de Asigurari AultCare/Aultra**. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la **Locale : 330.363.6360 In afara Stark Judet : 1.800.344.8858 TTY linie Locale : 711 In afara Stark Judet : 711**.

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### Non-Discrimination Notice:

AultCare/Aultra complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AultCare/Aultra does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AultCare/Aultra provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). AultCare/Aultra provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, or if you believe that AultCare/Aultra has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can contact or file a grievance with the: AultCare/Aultra Civil Rights Coordinator, 2600 6<sup>th</sup> St. S.W. Canton, OH 44710, 330-363-7456, [CivilRightsCoordinator@aultcare.com](mailto:CivilRightsCoordinator@aultcare.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

 MEDICAL MUTUAL®

## Dutch

LET OP: als je Nederlands spreekt, zijn er gratis taalhelpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-800-382-5729 (TTY: 711) of spreek met je provider.

## Pennsylvania Dutch

WICHDIH: Wann du Deitsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 1-800-382-5729 (TTY: 711) uff odder schwetz mit dei Provider.

## Ukrainian

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-382-5729 (TTY: 711) або зверніться до свого постачальника.

## Navajo

SHOOH: Diné bee y1ni[ti'gogo, saad bee an1'awo' bee 1ka'an7da'awo'7t'11 jiik'eh n1 h0l=. Bee ahi[ hane'go bee nida'anish7 t'11 1kodaat'4h7g77 d00 bee 1ka'an7da'wo'7 1ko bee baa hane'7 bee hadadilyaa bich'8' ahoot'i'7g77 47 t'11 jiik'eh h0l=. Kohj8' 1-800-382-5729 (TTY: 711) hod7ilnih doodago nika'an1lwo'7 bich'8' hanidzihi.

## Notice of Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Medical Mutual of Ohio complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Medical Mutual of Ohio does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Medical Mutual of Ohio:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

**If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator at [CivilRightsCoordinator@MedMutual.com](mailto:CivilRightsCoordinator@MedMutual.com).**

If you believe that Medical Mutual of Ohio has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

100 American Road  
Cleveland, OH 44144

Call: 1-800-382-5729 (TTY: 711)  
Email: [CivilRightsCoordinator@MedMutual.com](mailto:CivilRightsCoordinator@MedMutual.com)

You can file a grievance in person, by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator (who is also our Section 1557 Coordinator) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

### U.S. Department of Health and Human Services

200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

- Complaint forms are available at:  
<http://www.hhs.gov/ocr/office/file/index.html>
- This notice is available at Medical Mutual's website:  
[www.MedMutual.com](http://www.MedMutual.com)

**Questions about your benefits or other inquiries about your health insurance should be directed to Medical Mutual's Customer Care Department at 1-800-382-5729.**

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.