



**CANTON REGIONAL CHAMBER HEALTH FUND 2500 100 B with HRA**

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](http://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](http://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 <u>deductible</u> ?	For <u>network providers</u> \$2,500 Individual / \$5,000 Family For <u>out-of-network providers</u> \$7,500 Individual / \$15,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the calendar year <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Network preventive care</u> and services that apply a <u>copayment</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network medical providers</u> \$2,500 Individual / \$5,000 Family For <u>out-of-network providers</u> \$15,000 Individual/ \$30,000 Family For <u>Prescription Drugs</u> \$6,950 Individual/ \$13,900 Family	The <u>out-of-pocket limit</u> is the most you could pay in a calendar year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  <b>Your out-of-pocket expenses may be decreased through the Health Reimbursement Account (HRA).</b>

Important Questions	Answers	Why This Matters:
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><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 care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="http://www.aultcare.com">www.aultcare.com</a> or call 330-363-6360 or 1-800-344-8858 for a list of <a href="#">network providers</a>.</p>	<p>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.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copayment</a> /visit	20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply to office visits with a <a href="#">Network Provider</a> .
	<a href="#">Specialist</a> visit	\$25 <a href="#">copayment</a> /visit	20% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No cost share	50% <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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required.
<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.aultcare.com">www.aultcare.com</a>  This plan follows the Premium Managed Formulary.	Preferred Generic drugs (Tier 1)	<b>Retail 1-34 day supply:</b> \$10 <a href="#">copayment</a> or 20% <a href="#">coinsurance</a> , whichever is greater; <b>Retail 35-60 day supply:</b> \$20 <a href="#">copayment</a> or 20% <a href="#">coinsurance</a> , whichever is greater; <b>Mail order 90-day supply:</b> \$25 <a href="#">copayment</a> or 20% <a href="#">coinsurance</a> , whichever is greater		<a href="#">Deductible</a> does not apply. A 34-day supply is available at the retail pharmacy for brand name <a href="#">prescription drugs</a> . Up to a 60-day supply of Preferred generic <a href="#">prescription drugs</a> is available at the retail pharmacy, and a 90-day supply of generic or brand name <a href="#">prescription drugs</a> are available at the mail order program. Specialty/Limited Distribution Medications are limited to a 30-day supply. If a <a href="#">prescription drug</a> is purchased without using your card, this <a href="#">Plan</a> will pay up to the <a href="#">allowed amount</a> . <b>Specialty Medications must be obtained from AultCare's Preferred Specialty pharmacies. Prescription medication coupon, discount, or other manufacturer assistance programs for Specialty or other qualified medications will not apply</b>
	Preferred Brand / Non-Preferred Generic drugs (Tier 2)	<b>Retail 1-34 day supply:</b> \$30 <a href="#">copayment</a> or 30% <a href="#">coinsurance</a> , whichever is greater; <b>Mail order 90-day supply:</b> \$85 <a href="#">copayment</a> or 25% <a href="#">coinsurance</a> , whichever is greater, up to a maximum of \$200		
	Non-Preferred Brand / Non-Preferred Generic drugs (Tier 3)	<b>Retail 1-34 day supply:</b> \$45 <a href="#">copayment</a> or 50% <a href="#">coinsurance</a> , whichever is greater; <b>Mail order 90-day supply:</b> \$130 <a href="#">copayment</a> or 45% <a href="#">coinsurance</a> , whichever is greater, up to a maximum of \$400		

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.aultcare.com](http://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)	
	Specialty Generic (Tier 4)	<b>Retail or Mail order (30-day supply):</b> \$10 <a href="#">copayment</a> or 20% <a href="#">coinsurance</a> , whichever is greater		toward your <a href="#">Deductible</a> or <a href="#">Out-of-Pocket Maximum</a> . Certain Generic Medications may be subject to an incentive which may reduce member cost share under the Generic Incentive Program. Certain preventive medications may be covered at 100%, with no cost to You. Also, certain classes of medications require a Prior Authorization or Step Therapy. For a complete list of these medications please visit the AultCare website at <a href="http://www.aultcare.com">www.aultcare.com</a> .
	Specialty Brand (Tier 5)	<b>Retail or Mail order (30-day supply):</b> \$125 <a href="#">copayment</a> or 20% <a href="#">coinsurance</a> , whichever is greater		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copayment</a> /visit	\$150 <a href="#">copayment</a> /visit	<a href="#">Deductible</a> does not apply to this service.
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> will apply.
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment</a> /visit	\$50 <a href="#">copayment</a> /visit	<a href="#">Deductible</a> does not apply to this service.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance	Outpatient services	Benefits paid based on the corresponding medical benefit.	Benefits paid based on the corresponding medical benefit.	Services for Mental Health, Behavioral Health, or Substance Abuse are payable on the same basis as any other illness.

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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	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended.
<b>If you are pregnant</b>	Office visits	Benefits paid based on the corresponding medical benefit.	Benefits paid based on 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 <a href="#">copayment</a> , <a href="#">deductible</a> or <a href="#">coinsurance</a> may apply.
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended. Coverage is limited to 60 visits per calendar year.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Must be injury/illness related. Manipulation therapy is limited to 35 treatments per calendar year.
	<a href="#">Autism Spectrum Disorder</a>	Benefits paid based on the corresponding medical benefit.	Benefits paid based on the corresponding medical benefit.	Coverage is limited to Autism Spectrum Disorder. Services are limited to the following: Speech/Language/Occupational Therapy - 20 visits per calendar year for each service; and Clinical Therapeutic Intervention including ABA at 20 hours per week; and Mental/ Behavioral Health Outpatient Services.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended. Coverage is limited to 50 days per calendar year.

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)	
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended for a single item with a purchase price over \$2,500.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended.
<b>If your child needs dental or eye care</b>	Children's eye exam	No cost share	50% <a href="#">coinsurance</a>	Coverage is provided for vision screening for all children at least once through age 18 years, to detect the presence of amblyopia or its risk factors.
	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>Cosmetic Surgery</li> <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> <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> </ul>	<ul style="list-style-type: none"> <li>Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <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.

**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

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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 or call the Ohio Department of Insurance 1-800-686-1526.

#### **Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

#### **Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

#### **Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 330-363-6360 / 1-800-344-8858.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 330-363-6360 / 1-800-344-8858.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 330-363-6360 / 1-800-344-8858.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo 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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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,570</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,140
<a href="#">Copayments</a>	\$670
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,830</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,840
<a href="#">Copayments</a>	\$210
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,050</b>

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