




CANTON REGIONAL CHAMBER HEALTH FUND 5000 F


Coverage for: Individual/Family Plan Type: HDHP

 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:
<p>What is the overall <u>deductible</u>?</p>	<p>For <u>network providers</u> \$5,000 Individual / \$10,000 Family For <u>out-of-network providers</u> \$15,000 Individual /\$30,000 Family</p>	<p>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>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. <u>Network preventive care</u> services are covered before you meet your <u>deductible</u>.</p>	<p>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 https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>

Important Questions	Answers	Why This Matters:
<p>What is the out-of-pocket limit for this plan?</p>	<p>For network providers (medical/prescription drugs): \$5,000 Individual / \$10,000 Family</p> <p>Once met, additional Out-of-Pocket (Prescription Drug copayments only) \$750 Individual / \$1,500 Family</p> <p>For out-of-network providers \$22,050 Individual /\$44,100 Family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, 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 out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.aultcare.com or call 330-363-6360 or 1-800-344-8858 for a list of network providers.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.aultcare.com.]

 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	0% coinsurance	20% coinsurance	None
	Specialist visit	0% coinsurance	20% coinsurance	None
	Preventive care/screening/immunization	No cost share	50% coinsurance	Deductible does not apply for Out-of-Network well child care. 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)	0% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aultcare.com This plan follows the Premium Managed Formulary.	Preferred Generic drugs (Tier 1)	After Network Deductible is met: Retail 1-34 day supply: \$10 copayment ; Retail 35-60 day supply: \$20 copayment ; Mail order 90 day supply: \$25 copayment		Once the network medical/prescription out-of-pocket limit is reached, a tiered prescription drug copayment structure will apply. Copayments will track toward the additional prescription drug out-of-pocket limit of \$750 Individual / \$1,500 Family. A 34-day supply is available at the retail pharmacy for brand name prescription drugs . Up to a 60-day supply of Preferred generic prescription drugs is available at the retail pharmacy, and a 90-day supply of generic or brand name prescription
	Preferred Brand / Non-Preferred Generic drugs (Tier 2)	After Network Deductible is met: Retail 1-34 day supply: \$30 copayment ; Mail order 90 day supply: \$85 copayment		

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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)	
	Non-Preferred Brand / Non-Preferred Generic drugs (Tier 3)	After Network Deductible is met: Retail: \$60 copayment or 50% coinsurance , whichever is greater; Mail order: \$170 copayment / prescription		drugs are available at the mail order program. Specialty/Limited Distribution Medications are limited to a 30-day supply. If a prescription drug is purchased without using your card, this Plan will pay up to the allowed amount . 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 toward your Deductible or Out-of-Pocket Maximum. 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 www.aultcare.com .
	Specialty Generic (Tier 4)	Retail or Mail order (30-day supply): \$10 copayment or 20% coinsurance , whichever is greater		
	Specialty Brand (Tier 5)	Retail or Mail order (30-day supply): \$125 copayment or 20% coinsurance , whichever is greater		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Network Deductible will apply.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Network Deductible will apply.

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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)	
	Urgent care	0% coinsurance	0% coinsurance	Network Deductible will apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Preauthorization is recommended.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	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.
	Inpatient services	0% coinsurance	20% coinsurance	Preauthorization is recommended.
If you are pregnant	Office visits	Benefits paid based on the corresponding medical benefit.	Benefits paid based on the corresponding medical benefit.	Cost sharing does not apply to certain preventive services . Depending on the type of service, deductible or coinsurance may apply.
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	Preauthorization is recommended.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Preauthorization is recommended. Coverage is limited to 60 visits per calendar year.
	Rehabilitation services	0% coinsurance	20% coinsurance	Must be injury/illness related. Manipulation therapy is limited to 35 treatments per calendar year.

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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)	
	Autism Spectrum Disorder	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.
	Skilled nursing care	0% coinsurance	20% coinsurance	Preauthorization is recommended. Coverage is limited to 50 days per calendar year.
	Durable medical equipment	0% coinsurance	20% coinsurance	Preauthorization is recommended for a single item with a purchase price over \$2,500.
	Hospice services	0% coinsurance	20% coinsurance	Preauthorization is recommended.
If your child needs dental or eye care	Children's eye exam	No cost share	50% coinsurance	Deductible does not apply for Out-of-Network well child care. 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Abortion (except in cases of rape, incest, or when the life of the mother is endangered, as allowed under applicable law) Acupuncture Bariatric Surgery 	<ul style="list-style-type: none"> Cosmetic Surgery Dental Care (adult) Hearing Aids Long Term Care 	<ul style="list-style-type: none"> Non-Emergency care when traveling outside the U.S. Routine Eye Care (Adult) Routine Foot Care Weight Loss Programs

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

- Chiropractic Care
- Infertility Treatment
- Private Duty Nursing

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? 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:

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.aultcare.com.]



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](#) \$5,000
- [Specialist coinsurance](#) 0%
- 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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,060

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist coinsurance](#) 0%
- 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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$40
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$5,060

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist coinsurance](#) 0%
- 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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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