

Health Care Benefit Chart

Issued & Underwritten by

AultCare Insurance Company

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NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

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Benefits Chart

This Benefits Chart is part of Your Certificate. It explains Your specific Coverage and Benefits, including what You need to pay, what We will pay, and the Limitations and Exclusions in the Group Policy between Your Employer and AultCare.

If You have questions, please call the AultCare Service Center at 1-330-363-6360 for Members in Stark County, or 1-800-344-8858 for Members outside Stark County. You can also visit our website at www.aultcare.com.

I. BENEFIT LEVELS UNDER THE GROUP POLICY BETWEEN YOUR EMPLOYER AND AULTCARE INSURANCE COMPANY

The level of Benefits You receive under Your Employer’s Group Policy, and the amount You must pay out-of-pocket, depend on whether You receive medical services from AultCare Providers. You usually will need to pay more out-of-pocket if You go to a Non-Network Provider.

Policy Provision	Network Provider	Non-Network Provider
<p>Copayment: The set dollar amount You pay out-of-pocket for each Doctor Office Visit. The Copayment does not count against Your Annual Deductible.</p>	<p>\$25 Primary Care Physician \$25 Specialist \$75 ER \$50 Urgent Care \$25 Telehealth Primary Care Physician \$25 Telehealth Specialist \$25 Teladoc</p>	<p>\$75 ER \$50 Urgent Care</p>
<p>Annual Deductible: The minimum amount You must pay Out-of-Pocket each year before Benefits are paid under the Policy for certain services. Deductible begins on January 1 of each Calendar Year. An Individual will not be required to pay more than the maximum Individual Deductible in a Calendar Year</p> <p>Your Plan has a Non-Integrated Embedded Deductible.</p>	<p>\$750 for an Individual \$1,500 for a Family</p>	<p>\$2,250 for an Individual \$4,500 for a Family</p>
<p>Coinsurance (Out-of-Pocket Expense): This is the percentage of medical expense You share with the Policy after You meet Your Annual Deductible and Copayment.</p>	<p>Your share of the charge 20%</p>	<p>Your share of the charge 40% plus any charges in excess of RBP</p>

<p>Annual Out-of-Pocket Maximum (Annual Max): This is the total amount You pay Out-of-Pocket in one Year before the Policy pays 100% of Your medical expenses. It does include Your Deductible, Copayment and Coinsurance. An Individual will not be required to pay more than the maximum Individual Out-of-Pocket in a Calendar Year</p> <p>Your Plan has a Non-Integrated Embedded Out-of-Pocket.</p>	<p>\$3,000 per Individual \$6,000 per Family</p> <p>Once You have met this maximum, the Policy begins to pay covered medical expenses at 100% , except penalties.</p>	<p>\$9,000 per Individual \$18,000 per Family</p> <p>Once You have met this maximum, the Policy begins to pay covered medical expenses at 100% RBP except penalties and any balances over and above RBP.</p>
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The Plan will cover services for an Emergency Medical Condition treated in any Hospital Emergency Department. Plans will not require Prior Authorization or impose any other administrative requirements or benefit limitations that are more restrictive than services received from a Network provider. If you seek Emergency Services from a Non-Network Provider, you may be billed for charges that exceed the Reference Based Pricing. This is called balance billing.

EMBEDDED DEDUCTIBLE means that each Member of a Family is looked upon as an Individual in regard to the Deductible. Once a member reaches the Individual Deductible, the plan's Coinsurance will apply. Any combination of Family members may satisfy the family Deductible; however, no Member may satisfy more than his or her Individual Deductible amount.

EMBEDDED OUT-OF-POCKET means that each Member of a Family is looked upon as an Individual in regard to the Out-of-Pocket. Once a Member reaches the individual Out-of-Pocket maximum, the plan will begin to pay at 100% of Eligible Expenses for that Member. Any combination of Family Members may satisfy the Family Out-of-Pocket at which time the Plan will begin to pay Eligible Medical Expenses at 100% for the entire Family; however, a single Member will not be required to satisfy more than his or her Individual Out-of-Pocket amount.

Non-Integrated: Network and Non-Network Deductibles do not accumulate towards each other.

Note: If You use Non-Network Providers, only the amount allowed by Reference Based Pricing will count toward Your Deductible. Your Deductible and Out-of-Pocket expenses for Non-Network Providers may be separate from Network Providers.

Deductible Carryover

The Plan also features a Deductible carryover benefit. This provision states that any expenses that track toward the Individual and Family Deductible for claims incurred in the last three (3) months of

a Calendar Year will also track toward the individual and Family Deductible for the next Calendar Year.

Claims Submission Time for this plan is 24 months from the date of service.

Ohio's House Bill 388 and the Federal "No Surprises Act establish patient protections including from Out-of-Network providers' surprise bills ("balance billing") for emergency care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain Out-of-Network Providers.

II. COVERED BENEFITS (SERVICES) UNDER YOUR EMPLOYER'S GROUP POLICY

Benefits Not Listed May Not Be Covered. If You have a question about Your Benefits, please contact your Employer or call the AultCare Service Center 330-363-6360 or 1-800-344-8858. All Network preventive services defined by federal law are covered without Cost to you.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>Allergy Extract</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Network Deductible Applies</p> <p>Coinsurance Applies after Deductible 20% RBP</p>
<p>Allergy Injections</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Allergy Testing 40 tests maximum per Calendar Year</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Anesthesia in Office	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Anesthesia Outpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Anesthesia Inpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Biofeedback In Office	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Biofeedback Outpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Biofeedback Inpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>Cardiac Rehabilitation</p> <p>Outpatient</p> <p>Phase III is not covered</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Cardiac Rehabilitation</p> <p>Inpatient</p> <p>Phase III is not covered</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Chemo/Radiation Therapy</p> <p>In Office</p> <p>Please note that orally administered cancer medication Coverage shall be no less favorable than Coverage for intravenous and injected cancer medications in accordance with state law.</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>Chemo/Radiation Therapy</p> <p>Outpatient</p> <p>Please note that orally administered cancer medication Coverage shall be no less favorable than Coverage for intravenous and injected cancer medications in accordance with state law.</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Chemo/Radiation Therapy</p> <p>Inpatient</p> <p>Please note that orally administered cancer medication Coverage shall be no less favorable than Coverage for intravenous and injected cancer medications in accordance with state law.</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Dialysis</p> <p>In Office</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Dialysis</p> <p>Outpatient</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>Dialysis</p> <p>Inpatient</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Autism Spectrum Disorder</p> <p>20 visits each service, each year, Physical Rehabilitation Services, Speech & Language and/or Occupational Therapy</p> <p>Mental/Behavioral health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans</p> <p>20 hours per week Clinical Therapeutic Intervention, therapies supported by empirical evidence, which includes and not limited to Applied Behavioral Analysis</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Infertility Testing</p> <p>In Office</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Infertility Testing Outpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Infertility Testing Inpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Infertility Treatment In Office Artificial Insemination and In Vitro are not covered	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

<p>Infertility Treatment</p> <p>Outpatient</p> <p>Artificial Insemination and In Vitro are not covered</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Infertility Treatment</p> <p>In Inpatient</p> <p>Artificial Insemination and In Vitro are not covered</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Injections (Medical) Outpatient Not including routine Immunizations	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Injections (Medical) In Office Not including routine Immunizations	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Injections (Medical) Inpatient Not including routine Immunizations	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Inpatient Hospital Admission	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Inpatient Hospital Physician	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Laboratory/X-Ray/Diagnostic In Office	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Laboratory/X-Ray/Diagnostic Outpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Laboratory/X-Ray/Diagnostic Inpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Mammography In Office (Medical Diagnosis)	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Mammography Outpatient (Medical Diagnosis)	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Mammography Inpatient (Medical Diagnosis)	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Maternity	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
Occupational Therapy In Office Illness or Injury Related	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
Occupational Therapy Outpatient Illness or Injury related	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
Occupational Therapy Inpatient Illness or Injury Related	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Office Visit Physician/Nurse Practitioner/Physician's Assistant Illness	<u>You Must Pay:</u> Copayment Applies After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Office Visit Physician/Nurse Practitioner/Physician's Assistant Injury	<u>You Must Pay:</u> Copayment Applies After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Telehealth Based on services rendered	<u>You Must Pay:</u> Copayment Applies After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>Organ Donor Coverage</p> <p>Coordinate with Donor's coverage unless donor expenses covered in global fee</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Organ Transplant Coverage</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Physical Therapy/Rehabilitation</p> <p>Inpatient Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Physical Therapy/Rehabilitation</p> <p>Outpatient Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Pre-Admission Testing	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
Prescription Drug Administered in Office	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
Respiratory Therapy In Office Illness or Injury Related	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Respiratory Therapy Outpatient Illness or Injury Related	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Respiratory Therapy Inpatient Illness or Injury Related	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Speech Therapy In Office Illness or Injury Related	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

<p>Speech Therapy</p> <p>Inpatient</p> <p>Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Speech Therapy</p> <p>Outpatient</p> <p>Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>Surgery/Facility Outpatient</p> <p>Does not include all related charges.</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Surgery/Facility Inpatient</p> <p>Does not include all related charges.</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Surgery-Physician/Surgeon Outpatient</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Surgery-Physician/Surgeon Inpatient</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Surgery Assistant Surgeon Outpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Surgery Assistant Surgeon Inpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Surgery Cosmetic/Reconstructive Prior Authorization Required	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

<p>Surgery</p> <p>Second Surgical Opinion</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Breast Reconstructive Surgery after Mastectomy</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Emergency and Urgent Care	Network Provider	Non-Network Provider
Emergency Care (See Definition of Emergency Services)	<u>You Must Pay:</u> Copayment Applies After Annual Max \$0	<u>You Must Pay:</u> Copayment Applies RBP
Urgent Care	<u>You Must Pay:</u> Copayment Applies After Annual Max \$0	<u>You Must Pay:</u> Copayment Applies RBP

Mental/Behavioral Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
Mental/Behavioral Health/Substance Abuse Outpatient Treatment Programs	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Mental/Behavioral Health/Substance Abuse/ Outpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Mental/Behavioral Health/Substance Abuse Inpatient	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Mental/Behavioral Health/Substance Abuse Office Visit	<u>You Must Pay:</u> Copayment Applies After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

Other Services	Network Provider	Non-Network Provider
Abortion Therapeutic-necessary to save the mother's life	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Ambulance	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Network Deductible Applies Coinsurance Applies after Deductible 20% RBP
Breast Prosthesis/Bra Six Post-Mastectomy Bras per Calendar Year max	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Durable Medical Equipment Prior Authorization needed for equipment that exceeds \$2,500	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

Other Services	Network Provider	Non-Network Provider
<p>Gene and Cell Therapy Services</p> <p>Prior Authorization Required</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Genetic Counseling</p> <p>Prior Authorization Required</p> <p>Benefit level dependent upon where services rendered</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Genetic Testing</p> <p>Prior Authorization Required</p> <p>Benefit level dependent upon where services rendered</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Home Health Care</p> <p>Prior Authorization Required Up to 60 visits per Calendar Year</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Other Services	Network Provider	Non-Network Provider
Hospice Care Prior Authorization Required	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Pain Management	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Private Duty Nursing Prior Authorization Required Up to 23 visits per Calendar Year maximum	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max \$0	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

<p>Skilled Nursing</p> <p>Prior Authorization Required</p> <p>50 visits per Calendar Year maximum</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>All Other Covered Services</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Preventive Care	Network Provider	Non-Network Provider
<p>Gynecological Pap Test Routine Screening</p>	<p>Benefit not subject to Cost Share if provided as a routine preventive care screening.</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Mammography (Routine Screening)</p>	<p>Benefit not subject to Cost Share if provided as a routine preventive care screening.</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Well Child Care</p>	<p>Benefit not subject to Cost Share if provided as a routine preventive care screening.</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

<p>Tobacco Cessation</p>	<p>Benefit not subject to Cost Share if provided as a preventive service.</p>	<p><u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP</p>
<p>Sterilization-Women</p> <p>Male Sterilization is also covered. Refer to Surgery benefit.</p> <p>Reversals are not covered</p>	<p>Benefit not subject to Cost Share if provided as a preventive service.</p>	<p><u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP</p>

Preventive Care	Network Provider	Non-Network Provider
Care Related Education (Diabetes Education, Wound Care, etc.)	Benefit not subject to Cost Share if provided as a preventive service.	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Colonoscopy Screening Outpatient/Office	Benefit not subject to Cost Share if provided as a routine preventive care service.	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Physical (Routine)	Benefit not subject to Cost Share if provided as a routine preventive care service.	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Women's Birth Control Covers all FDA approved contraceptives	Benefit not subject to Cost Share if provided as a routine preventive care service.	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP
Other Recommended Preventive Screenings, Immunizations and Services Required By Federal Law Check with The AultCare Service Center for a current list or visit: www.HealthCare.gov/center/regulations/prevention.html	Benefit not subject to Cost Share if provided as a routine preventive care service.	<u>You Must Pay:</u> Deductible Applies Coinsurance Applies after Deductible 40% RBP

Affiliate Providers	Network Provider	Non-Network Provider
<p>Manipulation Therapy</p> <p>35 visits maximum Per Calendar Year</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Massotherapy</p> <p>Massotherapy Covered if services rendered by an MD or Physical Therapist</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 20%</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>
<p>Podiatry Coverage</p>	<p><u>You Must Pay:</u> Copayment Applies</p> <p>After Annual Max \$0</p>	<p><u>You Must Pay:</u> Deductible Applies</p> <p>Coinsurance Applies after Deductible 40% RBP</p>

Retail Benefits		
Tier	Retail Copayment 1-34 Day Supply	Retail Copayment 35-60 Day Supply
Preferred Generic (1 st Tier)	\$10.00 or 20% whichever is greater	\$20.00 or 20% whichever is greater
A 60-day supply may be obtained at the retail pharmacy for Tier 1.		
Tier	Retail Copayment 1-34 Day Supply	
Preferred Brand and Non-Preferred Generic (2 nd Tier)	\$30.00 or 30% whichever is greater	
Non-Preferred Brand and Non-Preferred Generic (3 rd Tier)	\$45.00 or 50% whichever is greater	
Specialty Generic (4 th Tier)	\$10.00 or 20% whichever is greater	
Specialty Brand (5 th Tier)	\$125.00 or 20% whichever is greater	
Mail Order Benefits		
Tier	Mail Order Copayment 1-90 Day Supply	
Preferred Generic (1 st Tier)	\$25.00 or 20% whichever is greater	
Preferred Brand and Non-Preferred Generic (2 nd Tier)	\$85.00 or 25% whichever is greater Maximum of \$200.00	
Non-Preferred Brand and Non-Preferred Generic (3 rd Tier)	\$130.00 or 45% whichever is greater Maximum of \$400.00	
Specialty Generic (4 th Tier)	\$10.00 or 20% whichever is greater	
Specialty Brand (5 th Tier)	\$125.00 or 20% whichever is greater	
Copayment after your plan's Out-of-Pocket maximum of \$5,700 /single or \$11,400 /family is met = \$0		
A 34-day supply is available at the retail pharmacy. A 90-day supply may be obtained through the mail order program.		