Health Care Benefit Chart

Issued & Underwritten by

AultCare Insurance Company

Group Purchasing Plan III
January 1, 2022

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
Copayment: The set dollar amount You pay out-of-pocket for each Doctor Office Visit. The Copayment does not count against Your Annual Deductible.	$10 Primary Care Physician $10 Specialist $75 ER $50 Urgent Care $10 Telehealth Primary Care Physician $10 Telehealth Specialist $10 Teladoc	$75 ER $50 Urgent Care
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 **Your Plan has a Non-Integrated Embedded Deductible.**	$200 for an Individual $400 for a Family	$600 for an Individual $1,200 for a Family
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**.	Your share of the charge 10%	Your share of the charge 30% plus any charges in excess of RBP

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 **Your Plan has a Non-Integrated Embedded Out-of-Pocket.**	$700 per Individual $1,400 per Family Once You have met this maximum, the Policy begins to pay covered medical expenses at 100%, except penalties.	$2,100 per Individual $4,200 per Family 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.

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.

<u>Deductible Carryover</u>
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
Allergy Extract	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% RBP
Allergy Injections	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% RBP After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Allergy Testing **40 tests maximum per Calendar Year**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Anesthesia **in Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Anesthesia **Outpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Anesthesia **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Biofeedback **In Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Biofeedback **Outpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Biofeedback **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Cardiac Rehabilitation **Outpatient** **Phase III is not covered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Cardiac Rehabilitation **Inpatient** **Phase III is not covered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Chemo/Radiation Therapy **In Office** **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**.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Chemo/Radiation Therapy **Outpatient** **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**.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Chemo/Radiation Therapy **Inpatient** **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**.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Dialysis **In Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Dialysis **Outpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Dialysis **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Autism Spectrum Disorder **20 visits each service, each year, Physical Rehabilitation Services, Speech & Language and/or Occupational Therapy** **Mental/Behavioral health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans** **20 hours per week Clinical Therapeutic Intervention, therapies supported by empirical evidence, which includes and not limited to Applied Behavioral Analysis**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Infertility Testing **In Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Infertility Testing **Outpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Infertility Testing **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Infertility Treatment **In Office** **Artificial Insemination and In Vitro are not covered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Infertility Treatment **Outpatient** **Artificial Insemination and In Vitro are not covered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Infertility Treatment **In Inpatient** **Artificial Insemination and In Vitro are not covered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Injections (Medical) **Outpatient** **Not including routine Immunizations**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Injections (Medical) **In Office** **Not including routine Immunizations**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Injections (Medical) **Inpatient** **Not including routine Immunizations**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Inpatient Hospital Admission	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Inpatient Hospital **Physician**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Laboratory/X-Ray/Diagnostic **In Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Laboratory/X-Ray/Diagnostic **Outpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Laboratory/X-Ray/Diagnostic **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Mammography **In Office** **(Medical Diagnosis)**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Mammography **Outpatient** **(Medical Diagnosis)**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Mammography **Inpatient** **(Medical Diagnosis)**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Maternity	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Occupational Therapy **In Office** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Occupational Therapy **Outpatient** **Illness or Injury related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Occupational Therapy **Inpatient** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Office Visit Physician/Nurse Practitioner/Physician's Assistant Illness	You Must Pay: Copayment Applies After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Office Visit Physician/Nurse Practitioner/Physician's Assistant Injury	You Must Pay: Copayment Applies After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Telehealth **Based on services rendered**	You Must Pay: Copayment Applies After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Organ Donor Coverage **Coordinate with Donor's coverage unless donor expenses covered in global fee**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Organ Transplant Coverage	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Physical Therapy/Rehabilitation **Inpatient Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Physical Therapy/Rehabilitation Outpatient Illness or Injury Related	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Pre-Admission Testing	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Prescription Drug **Administered in Office**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Respiratory Therapy **In Office** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Respiratory Therapy **Outpatient** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Respiratory Therapy **Inpatient** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Speech Therapy **In Office** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Speech Therapy **Inpatient** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Speech Therapy **Outpatient** **Illness or Injury Related**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Surgery/Facility Outpatient **Does not include all related charges.**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Surgery/Facility **Inpatient** **Does not include all related charges.**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Surgery-Physician/Surgeon **Outpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Surgery-Physician/Surgeon **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Surgery **Assistant Surgeon** **Outpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Surgery **Assistant Surgeon** **Inpatient**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Surgery **Cosmetic/Reconstructive** **Prior Authorization Required**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Surgery **Second Surgical Opinion**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Breast Reconstructive Surgery after Mastectomy	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

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

Mental/Behavioral Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
Mental/Behavioral Health/Substance Abuse **Outpatient Treatment Programs**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Mental/Behavioral Health/Substance Abuse/ Outpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Mental/Behavioral Health/Substance Abuse Inpatient	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Mental/Behavioral Health/Substance Abuse **Office Visit**	You Must Pay: Copayment Applies After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Other Services	Network Provider	Non-Network Provider
Abortion **Therapeutic-necessary to save the mother's life**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Ambulance	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 20% After Annual Max $0	You Must Pay: Network Deductible Applies Coinsurance Applies after Deductible 20% RBP
Breast Prosthesis/Bra **Six Post-Mastectomy Bras per Calendar Year max**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Durable Medical Equipment **Prior Authorization needed for equipment that exceeds $2,500**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Other Services	Network Provider	Non-Network Provider
Gene and Cell Therapy Services **Prior Authorization Required**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Genetic Counseling **Prior Authorization Required** **Benefit level dependent upon where services rendered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Genetic Testing **Prior Authorization Required** **Benefit level dependent upon where services rendered**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Home Health Care **Prior Authorization Required** **Up to 60 visits per Calendar Year**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Other Services	Network Provider	Non-Network Provider
Hospice Care **Prior Authorization Required**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Pain Management	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Private Duty Nursing **Prior Authorization Required** **Up to 19 visits per Calendar Year maximum for Network and 14 visits per Calendar Year maximum for Non-Network**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Skilled Nursing **Prior Authorization Required** **50 visits per Calendar Year maximum**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
All Other Covered Services	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Preventive Care	Network Provider	Non-Network Provider
Gynecological Pap Test **Routine Screening**	Benefit not subject to Cost Share if provided as a routine preventive care screening.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Mammography **(Routine Screening)**	Benefit not subject to Cost Share if provided as a routine preventive care screening.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Well Child Care	Benefit not subject to Cost Share if provided as a routine preventive care screening.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Tobacco Cessation	Benefit not subject to Cost Share if provided as a preventive service.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Sterilization-Women **Male Sterilization is also covered. Refer to Surgery benefit.** **Reversals are not covered**	Benefit not subject to Cost Share if provided as a preventive service.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

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.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Colonoscopy Screening **Outpatient/Office**	Benefit not subject to Cost Share if provided as a routine preventive care service.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Physical **(Routine)**	Benefit not subject to Cost Share if provided as a routine preventive care service.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Women's Birth Control **Covers all FDA approved contraceptives**	Benefit not subject to Cost Share if provided as a routine preventive care service.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% 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.	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Affiliate Providers	Network Provider	Non-Network Provider
Manipulation Therapy **35 visits maximum Per Calendar Year**	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Massotherapy Massotherapy Covered if services rendered by an MD or Physical Therapist	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 10% After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP
Podiatry Coverage	You Must Pay: Copayment Applies After Annual Max $0	You Must Pay: Deductible Applies Coinsurance Applies after Deductible 30% RBP

Retail Benefits		
Tier	**Retail Copayment 1-34 Day Supply**	**Retail Copayment 35-60 Day Supply**
Preferred Generic (1st 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 (2nd Tier)		$30.00 or 30% whichever is greater
Non-Preferred Brand and Non-Preferred Generic (3rd Tier)		$45.00 or 50% whichever is greater
Specialty Generic (4th Tier)		$10.00 or 20% whichever is greater
Specialty Brand (5th Tier)		$125.00 or 20% whichever is greater
Mail Order Benefits		
Tier		**Mail Order Copayment 1-90 Day Supply**
Preferred Generic (1st Tier)		$25.00 or 20% whichever is greater
Preferred Brand and Non-Preferred Generic (2nd Tier)		$85.00 or 25% whichever is greater Maximum of $200.00
Non-Preferred Brand and Non-Preferred Generic (3rd Tier)		$130.00 or 45% whichever is greater Maximum of $400.00
Specialty Generic (4th Tier)		$10.00 or 20% whichever is greater
Specialty Brand (5th Tier)		$125.00 or 20% whichever is greater
Copayment after your plan's Out-of-Pocket maximum of $8,000 /single or $16,000 /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.		