

# Health Care Benefit Chart

Issued & Underwritten by  
McKinley Life Insurance Company

MY HOSPITAL



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.

MLIC Benefits Chart 2009-My Hospital Maximums). Benefits Not Listed are Not 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.  
MLIC Benefits Chart 2009-My Hospital

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MLIC Benefits Chart 2009-My Hospital

## Benefits\* Chart

This Benefits Chart (also called "Schedule of Benefits") 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 AultCare's Service Center at (330) 363-6360 or 1-800-344-8858. You also can email Us at [www.aultcare.com](http://www.aultcare.com).

### **I. DESCRIPTION OF REQUIREMENTS AND TERMS UNDER THE MASTER GROUP POLICY BETWEEN YOUR EMPLOYER AND MCKINLEY LIFE INSURANCE COMPANY**

#### **Your Eligibility Requirements**

- Full-time Employee means that You are on Your Employer's W-2 payroll and work a minimum average of 25 hours per week. If Your Employer is a "Small Employer" with at least 2 but not more than 50 employees, then Full-time Employee means that You are on Your Employer's W-2 payroll and work a minimum average of 25 hours per week.
- A Dependent Child will remain eligible until the end of the month in which the Child reaches age 19 unless the Child is a Full-time Student or has a physical or mental handicap.
- Full-time Student means the Child is under the age of 24 and is taking the minimum number of hours per semester at a college, university, or trade school. Coverage will cease at the end of the month the Child attains age 24. The Student also must be unmarried and must depend on You for main support according to IRS Dependent guidelines. In the event an otherwise eligible Full-Time Student must take a Medically Necessary leave of absence or changes to part-time status due to a Medically Necessary leave of absence, coverage will continue for 12 months provided the Employee remains on the Plan.

#### **Your Waiting Period**

- Your Coverage will be Effective after You apply for Coverage and agree in writing to pay the required Contributions. Coverage will begin on the first day of the month following the day You become eligible, unless Your Employer has a Waiting Period.
- If you are covered under Special Enrollment, Coverage will begin on the day of the Triggering Event, provided that You apply for Coverage and agree in writing to pay the required Contributions within the Special Enrollment Period.
- If you are a Late Applicant (See Section 41), Coverage will begin on the first day of the month following the day You apply for Coverage and agree in writing to pay the required Contributions.

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

## Your Employer's Enrollment Periods

- Initial Enrollment Period runs for 31 days beginning on date of hire.
- You will have a Pre-Existing Medical Condition Exclusionary period of 12 months.
- Special Dependent Enrollment runs for 31 days, beginning on the Triggering Event, such as marriage, birth, adoption, or placement for adoption.
- Special Enrollment runs for 31 days, beginning on the Triggering Event, such as marriage, birth, adoption, or placement for adoption.

## Your Coverage Ends

Your Coverage will end at the earliest of:

1. The date coverage ends for everyone under the terms of Your Employer's Master Group Policy.
2. The end of the period for which the last Premium has been paid for You;
3. The date Your Employer's Master Group Policy ends;
4. The end of the period for which You made the last contribution;
5. The last day of the Coverage Month of the date employment ends; except as stated in the Right To Continue Coverage provision. Falling below the average minimum necessary to maintain full-time status may be considered end of employment for purposes of determining when Coverage ends.
6. The last day of the Coverage Month in which You request termination, but not prior to the date of the request;
7. The last day of the Coverage Month in which You retire or get Your pension (unless the Benefits Chart includes a specific classification for retired or pensioned Persons);
8. The last day of the Coverage Month in which You enter active military service for any country, except for temporary duty of 30 days or less, or when a reservist is ordered to active duty, as provided by Ohio law;
9. The last day of the Coverage Month in which You cease to be Actively At Work, except if You cease to be Actively At Work due to Sickness or Accidental Bodily Injury, hospitalization Coverage will continue until the earliest of the following:
  - a. The 365<sup>th</sup> day after ceasing to be Actively At Work; or
  - b. A period of time equal to same amount of time You were insured under the Master Group Policy while Actively At Work; or
  - c. The last day of the Coverage Month for which the last contribution is made; or
  - d. Discharge from the hospital for episode of care; or
  - e. Inpatient care no longer is Medically Necessary; or

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- f. The Benefit Limit under the Master Group Policy has been reached; or
- g. Coverage by another carrier begins.

### **Your Dependent's Coverage Ends:**

Dependent Coverage will end at the earliest of:

1. The date Your Coverage ends;
2. The date Dependent Coverage ends under the Master Group Plan;
3. The last day of the Coverage Month during which the Person ceases to be a Dependent;
4. The end of the period for which the last Premium has been paid for the Dependent;
5. The end of the period for which the last Contribution was made by You for Your Dependent;
6. The date the Master Group Policy is terminated;
7. The last day of the Coverage Month in which the Dependent becomes a member; or
8. Discharge from the hospital for episode of care.

### **Rehires**

#### **Individual Reinstatements**

- If your Insurance terminates due to lay-off or discharge your insurance may be reinstated upon return to full-time employment. The following apply:
  - Your return occurs within 14 days of your termination date, your insurance becomes effective upon the date of return.
  - Your return occurs more than 14 days after your termination date, you will be considered a new employee.

#### **Maximum Time to Submit a Claim**

The maximum time in which to submit a claim in order for it to be processed is 24 months.

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

## II. BENEFIT LEVELS UNDER THE GROUP POLICY BETWEEN YOUR EMPLOYER AND MCKINLEY LIFE 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 Network 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
<b>Co-pay:</b> The set dollar amount You pay out-of-pocket for each Doctor Office Visit. The co-pay does not count against Your Annual Deductible. [Application of Copay is dependent upon services rendered].	[0-\$25] [Primary Care Physician] [0-\$50] [Specialist]	\$0
<b>Annual Deductible:</b> The minimum amount You must pay out-of-pocket each year before Benefits are paid under the Policy.	[\$0 - \$5,000 for an individual] [\$0 - \$10,000 for a family]	[\$0-\$7,500 for an individual] [\$200 - \$15,000 for a family]
<b>Co-insurance (Out-of-Pocket Expense):</b> This is the percentage of medical expense You share with the Policy after You meet Your <b>Annual Deductible and Co-pay</b> .	Your share of the charge: <u>Network [(Aultman Hospital)]</u> -0% <u>IHN</u> -20% <u>Other Network</u> -30%	Your share of the charge: 40% plus any charges in excess of UCR
<b>Annual Out-of-Pocket Maximum (Annual Max):</b> 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. It does not include Co-payments.	[\$0 - \$5,000 per individual] [\$0 - \$10,000 per family]  Once You have met this maximum, the Policy begins to pay covered medical expenses at 100% except for penalties, benefits paid at 50% and non-emergency care which are not included in the 100% reimbursement provision.	[\$300 - \$10,000 per individual] [\$0 - \$20,000 per family]  Once You have met this maximum, the Policy begins to pay covered medical expenses at 100% except for penalties, benefits paid at 50% and non-emergency care which are not included in the 100% reimbursement provision.
<b>Annual Plan Maximum:</b> This is the total amount your plan will pay in one year.	[\$100,000] per Employee [\$100,000] per Spouse [\$50,000] per Dependent Child	[\$100,000] per Employee [\$100,000] per Spouse [\$50,000] per Dependent Child
<b>Lifetime Maximum</b> \$2,000 reinstatement	[\$7,500 - \$5,000,000] [Unlimited]	[\$7,500 - \$5,000,000] [Unlimited]
<b>Penalty If You Do Not Get Pre-Approval</b>		50% up to \$500 to Enrollee

Note: If You use Non-Network Providers, only what is paid up to UCR will count toward Your Deductible. Your Deductible and Out-of-Pocket expenses for Non-Network Providers may be separate from Network Providers.

**\*BENEFIT LIMITATIONS MAY APPLY\***

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

**Definitions used in this Benefits Chart:**

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

**Embedded** – An Embedded Deductible has a family Deductible however, “Embedded” within it is an individual Deductible. Usually the individual Deductible is half or one-third of the family Deductible. Embedded Deductibles are what people are generally used to when they have a traditional health plan or PPO plan.

**Network** – [Aultman] Hospital, Primary Network Inpatient Hospital.

**Independent Hospital Network (IHN)** – Other Network Hospitals listed in your Provider Directory.

**Other Network** – Summa Hospital

**Non-Network** – Inpatient Hospitals not listed as Network Hospitals in your Provider Directory.

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**III. COVERED BENEFITS (SERVICES) UNDER YOUR EMPLOYER'S GROUP POLICY\***

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Allergy Extract	<p><u>You Must Pay:</u>  Deductible      [\$0-\$10,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible      [\$0-\$15,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [60-100%]  [After Annual Max 100%]</p>
Allergy Injections	<p><u>You Must Pay:</u>  Deductible      [\$0-\$10,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible      [\$0-\$15,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [60-100%]  [After Annual Max 100%]</p>
Allergy Testing  40 tests maximum per Calendar Year	<p><u>You Must Pay:</u>  Deductible      [\$0-\$10,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible      [\$0-\$15,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<b>Anesthesia In Office</b>	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
<b>Anesthesia Outpatient</b>  See page E for Hospital Definitions  Services rendered at Aultman Hospital will be paid at 100% of billed charges.	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
<b>Anesthesia Inpatient</b>  Services rendered at Aultman Hospital will be paid at 100% of billed charges.  See page E for Hospital Definitions	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>[Bio-Feedback In Office]</b> <b>(Plan Approval Required)</b></p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p><b>[Bio-Feedback Outpatient]</b> <b>(Plan Approval Required)</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p><b>[Bio-Feedback Inpatient]</b> <b>(Plan Approval Required)</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>Cardiac Rehabilitation I &amp; II Outpatient</b></p> <p>Cardiac Rehab III not covered</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$10,000]</p> <p>Co-pay [\$0-\$50]</p> <p>Coinsurance Tiers</p> <p>IHN [0-20%]</p> <p>Other Panel [0-30%]</p> <p>[After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance Tiers</p> <p>IHN [80-100%]</p> <p>Other Panel [70-100%]</p> <p>[After Annual Max 100%]</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$15,000]</p> <p>Co-pay [\$0-\$50]</p> <p>Coinsurance [0-40%UCR]</p> <p>[After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance [60-100%]</p> <p>[After Annual Max 100%]</p>
<p><b>Cardiac Rehabilitation I &amp; II Inpatient</b></p> <p>Cardiac Rehab III not covered</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$10,000]</p> <p>Co-pay [\$0-\$50]</p> <p>Coinsurance Tiers</p> <p>IHN [0-20%]</p> <p>Other Panel [0-30%]</p> <p>[After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance Tiers</p> <p>IHN [80-100%]</p> <p>Other Panel [70-100%]</p> <p>[After Annual Max 100%]</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$15,000]</p> <p>Co-pay [\$0-\$50]</p> <p>Coinsurance [0-40%UCR]</p> <p>[After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance [60-100%]</p> <p>[After Annual Max 100%]</p>
<p><b>Chemo/Radiation Therapy In Office</b></p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$10,000]</p> <p>Co-pay [\$0-\$50]</p> <p>Coinsurance [0-30%]</p> <p>[After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance [70-100%]</p> <p>[After Annual Max 100%]</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$15,000]</p> <p>Co-pay [\$0-\$50]</p> <p>Coinsurance [0-40%UCR]</p> <p>[After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance [60-100%]</p> <p>[After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>Chemo/Radiation Therapy Outpatient</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Chemo/Radiation Therapy Inpatient</b></p> <p>See page E for Hospital Definitions</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Dialysis In Office</b></p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>[Infertility Testing Outpatient]</b>  <b>(Plan Approval Required)</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>[Infertility Testing Inpatient]</b>  <b>(Plan Approval Required)</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>[Infertility Treatment In Office]</b>  <b>(Plan Approval Required)</b></p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>[Infertility Treatment Outpatient]</b>  <b>(Plan Approval Required)</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>[Infertility Treatment Inpatient]</b>  <b>(Plan Approval Required)</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Injections (Medical) In Office</b></p> <p>Not including routine Immunizations</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>Injections (Medical) Outpatient</b></p> <p>Not including routine immunizations</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u></p> <p>Deductible [0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Injections (Medical) Inpatient</b></p> <p>Not including routine immunizations</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u></p> <p>Deductible [0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Inpatient Hospital Admission (Semi-Private room)</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u></p> <p>Deductible [0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>Inpatient Hospital Physician</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Laboratory/X-Ray/Diagnostic In Office</b></p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Laboratory/X-Ray/Diagnostic Outpatient</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>Mammography (Medical Diagnosis) Inpatient</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Maternity Enrollee/Spouse</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Maternity Dependent Care</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>[Occupational Therapy In Office]</p> <p>Illness or Injury Related</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p>[Occupational Therapy Outpatient]</p> <p>Illness or injury Related</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p>[Occupational Therapy Inpatient]</p> <p>Illness or injury Related</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>Office Visit Illness</b></p> <p>Email office visits limited to 4 times per Calendar Year</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Office Visit Injury</b></p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>[Organ Donor Coverage] [(Plan Approval Required)]</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

<b>Inpatient, Outpatient, and Physician Office Care</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<p><b>Organ Transplant Coverage (Plan Approval Required)</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital definitions</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>[Physical Therapy In Office]</b></p> <p>Illness or Injury Related</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>[Physical Therapy Outpatient]</b></p> <p>Illness or injury Related</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u></p> <p>Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>[Physical Therapy Inpatient]</b> Illness or injury Related</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p><b>Pre-Admission Testing</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p><b>Prescription Drugs Administered in Office</b></p>	<p><u>You Must Pay:</u> Deductible [0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

<b>Inpatient, Outpatient, and Physician Office Care</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Rehabilitation Therapy In Office</b> Illness or Injury Related	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
<b>Rehabilitation Therapy Outpatient</b> Illness or injury Related  Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.  See page E for Hospital Definitions	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
<b>Rehabilitation Therapy Inpatient</b>  Illness or injury Related  Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.  See page E for Hospital Definitions	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>[Speech Therapy In Office] Illness or Injury Related</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>[Speech Therapy Outpatient] Illness or injury Related Services rendered at [Aultman] Hospital will be paid at 100% of billed charges. See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>[Speech Therapy Inpatient] Illness or injury Related Services rendered at [Aultman] Hospital will be paid at 100% of billed charges. See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>Surgery In Office</b></p>	<p><u>You Must Pay:</u>  Deductible [\\$0-\$10,000]  Co-pay [\\$0-\$50]  Coinsurance [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\\$0-\$15,000]  Co-pay [\\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Surgery Outpatient (Sameday)</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\\$0-\$10,000]  Co-pay [\\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\\$0-\$15,000]  Co-pay [\\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Surgery Inpatient</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\\$0-\$10,000]  Co-pay [\\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\\$0-\$15,000]  Co-pay [\\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p>Surgery Assistant Surgeon Outpatient</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>Surgery Assistant Surgeon Inpatient</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>Surgery Cosmetic/Reconstructive</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] [Coinsurance] Tiers [0-30%] IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> [Coinsurance] Tiers [70-100%] IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<p><b>Surgery</b>  <b>Second Surgical Opinion</b></p> <p>Maximum penalty of 50% to Enrollee up to \$500 for Non-Network Providers</p> <p>Required for Septo-rhino, tenotomy, Reconstructive-cosmetic, vein surgeries</p>	<p><u>You Must Pay:</u></p> <p>Deductible       [\$0-\$10,000]  Co-pay           [\$0-\$50]  Coinsurance      [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance      [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u></p> <p>Deductible       [\$0-\$15,000]  Co-pay           [\$0-\$50]  Coinsurance      [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u></p> <p>Coinsurance      [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Emergency and Urgent Care	Network Provider	Non-Network Provider
<b>Emergency Care Approved Emergency (See Definition of Emergency Services)</b>	<u>You Must Pay:</u> Deductible       [\$0-\$10,000] Co-pay           [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$0-\$15,000] Co-pay           [\$0-\$50] Coinsurance     [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [60-100%] [After Annual Max 100%]
<b>Non-Emergency (See Definition of Emergency Services)</b>	<u>You Must Pay:</u> Deductible       [\$0-\$10,000] Co-pay           [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$0-\$15,000] Co-pay           [\$0-\$50] Coinsurance     [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [60-100%] [After Annual Max 100%]
<b>Emergency Care Out of Service Area</b>	<u>You Must Pay:</u> Deductible       [\$0-\$10,000] Co-pay           [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$0-\$15,000] Co-pay           [\$0-\$50] Coinsurance     [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [60-100%] [After Annual Max 100%]

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Emergency and Urgent Care	Network Provider	Non-Network Provider
Urgent Care	<p><u>You Must Pay:</u>  Deductible      [\$0-\$10,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible      [\$0-\$15,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [60-100%]  [After Annual Max 100%]</p>
Urgent Care Non-Approved	<p><u>You Must Pay:</u>  Deductible      [\$0-\$10,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible      [\$0-\$15,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Mental Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
<p><b>Mental Health Outpatient</b> With Plan Approval, Services are paid the same as treatment for other physical illness or injury</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p><b>Mental Health Inpatient</b> With Plan Approval, Services are paid the same as treatment for other physical illness or injury</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p><b>Mental Health Outpatient Treatment Programs</b> With Plan Approval, Services are paid the same as treatment for other physical illness or injury</p> <p>See page E for Hospital Definitions</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Mental Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
<p><b>Alcohol/Substance Abuse Outpatient</b> With Plan Approval, Services are paid the same as treatment for other physical illness or injury</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p><b>Alcohol/Substance Abuse Inpatient</b> With Plan Approval, Services are paid the same as treatment for other physical illness or injury</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p><b>Alcohol/Substance Abuse Outpatient Treatment Programs</b> With Plan Approval, Services are paid the same as treatment for other physical illness or injury</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

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Other Services	Network Provider	Non-Network Provider
<p><b>[Abortion] Therapeutic</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>Ambulance</b></p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance [0-30%] [UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p><b>[Attention Deficit Disorder] (Plan Approval Required)</b></p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Other Services	Network Provider	Non-Network Provider
<p><b>[Bariatric Surgery]</b> <b>(Plan Approval Required)</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p> <p>For surgery when morbidly obese with severe health conditions AND documented history of repeated failure of physician supervised medical/dietary therapies</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p><b>Blood Replacement Programs</b> <b>(Blood not replaced)</b></p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p><b>Breast Prosthesis/Bra</b> <b>[Initial]</b></p> <p>Replacement prosthesis is covered if Medically Necessary</p> <p>Replacement bra is covered</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Other Services	Network Provider	Non-Network Provider
<b>[Durable Medical Equipment]</b> <b>(Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible       [\$0-\$10,000] Co-pay           [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$0-\$15,000] Co-pay           [\$0-\$50] Coinsurance     [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [60-100%] [After Annual Max 100%]
<b>[Genetic Counseling]</b> <b>(Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible       [\$0-\$10,000] Co-pay           [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$0-\$15,000] Co-pay           [\$0-\$50] Coinsurance     [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [60-100%] [After Annual Max 100%]
<b>[Growth Hormone Treatment]</b>	<u>You Must Pay:</u> Deductible       [\$0-\$10,000] Co-pay           [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$0-\$15,000] Co-pay           [\$0-\$50] Coinsurance     [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [60-100%] [After Annual Max 100%]

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Other Services	Network Provider	Non-Network Provider
[Hepatitis Vaccination High Risk]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
Home Health Care (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
[Hospice Care] (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Other Services	Network Provider	Non-Network Provider
<p>[Pain Management] (Plan Approval Required)</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>Private Duty Nursing (Plan Approval Required)</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>[Psychological/Personality Testing]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Other Services	Network Provider	Non-Network Provider
<b>Skilled Nursing (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible      [\$0-\$10,000] Co-pay            [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]  	<u>You Must Pay:</u> Deductible      [\$0-\$15,000] Co-pay            [\$0-\$50] Coinsurance     [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [60-100%] [After Annual Max 100%]  
<b>[Smoking Cessation]</b>	<u>You Must Pay:</u> Deductible      [\$0-\$10,000] Co-pay            [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]  	<u>You Must Pay:</u> Deductible      [\$0-\$15,000] Co-pay            [\$0-\$50] Coinsurance     [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [60-100%] [After Annual Max 100%]  
<b>[Sterilization]</b>	<u>You Must Pay:</u> Deductible      [\$0-\$10,000] Co-pay            [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]  	<u>You Must Pay:</u> Deductible      [\$0-\$15,000] Co-pay            [\$0-\$50] Coinsurance     [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [60-100%] [After Annual Max 100%]  

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Other Services	Network Provider	Non-Network Provider
[Temporomandibular Joint Dysfunction] (Plan Approval Required)	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Educational Training	Network Provider	Non-Network Provider
<p>[Diabetic Education Outpatient] (Plan Approval Required)</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p>[Diabetic Education Inpatient] (Plan Approval Required)</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>
<p>[Educational Training Outpatient] (Plan Approval Required)</p> <p>Medically Necessary</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$10,000]  Co-pay [\$0-\$50]  Coinsurance Tiers  IHN [0-20%]  Other Panel [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance Tiers  IHN [80-100%]  Other Panel [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$0-\$15,000]  Co-pay [\$0-\$50]  Coinsurance [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Educational Training	Network Provider	Non-Network Provider
<p>[Educational Training Inpatient] (Plan Approval Required)</p> <p>Medically Necessary</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>[Nutritional Education Outpatient]</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>
<p>[Nutritional Education Inpatient]</p> <p>Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.</p> <p>See page E for Hospital Definitions</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance Tiers IHN [0-20%] Other Panel [0-30%] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance Tiers IHN [80-100%] Other Panel [70-100%] [After Annual Max 100%]</p>	<p><u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]</p> <p><u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Preventive Care	Network Provider	Non-Network Provider
<p><b>Gynecological Pap Test</b></p>	<p><u>You Must Pay:</u>  Deductible      [\$0-\$10,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible      [\$0-\$15,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-50%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [50-100%]  [After Annual Max 100%]</p>
<p><b>Mammography (Routine Screening)</b></p> <p>Coinsurance is applied to 130% of the Reimbursed Medicare Amount. The total benefit for a screening mammography shall not exceed 130% of the Reimbursed Medicare Amount. Amount shall constitute payment in full.</p>	<p><u>You Must Pay:</u>  Deductible      [\$0-\$10,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible      [\$0-\$15,000]  Co-pay            [\$0-\$50]  Coinsurance     [0-50%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [50% -100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

<p><b>[Well Child Care]</b>  (Hearing Screening included for 0-12 months, benefit not to exceed \$75.)</p>	<p><u>You Must Pay:</u>  Deductible       [\$0-\$10,000]  Co-pay           [\$0-\$50]  Coinsurance     [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible       [\$0-\$15,000]  Co-pay           [\$0-\$50]  Coinsurance     [0-50%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [50-100%]  [After Annual Max 100%]</p>
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\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

<b>Preventive Care</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Breast Reconstructive Surgery after Mastectomy</b>  Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.  See page E for Hospital Definitions	<u>You Must Pay:</u> Deductible      [\$0-\$10,000] Co-pay            [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$0-\$15,000] Co-pay            [\$0-\$50] Coinsurance     [0-50%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [50-100%] [After Annual Max 100%]
<b>[Colonoscopy] [Outpatient/Office]</b>  Services rendered at [Aultman] Hospital will be paid at 100% of billed charges.  See page E for Hospital Definitions	<u>You Must Pay:</u> Deductible      [\$0-\$10,000] Co-pay            [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$0-\$15,000] Co-pay            [\$0-\$50] Coinsurance     [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [60-100%] [After Annual Max 100%]
<b>[Gynecological Exam]</b>	<u>You Must Pay:</u> Deductible      [\$0-\$10,000] Co-pay            [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$0-\$15,000] Co-pay            [\$0-\$50] Coinsurance     [0-50%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [50-100%] [After Annual Max 100%]
<b>[Immunizations Beyond Well Child Care]</b>	<u>You Must Pay:</u> Deductible      [\$0-\$10,000] Co-pay            [\$0-\$50] Coinsurance     [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$0-\$15,000] Co-pay            [\$0-\$50] Coinsurance     [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [60-100%] [After Annual Max 100%]

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Preventive Care	Network Provider	Non-Network Provider
[Physical (Routine)]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40% UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

[Ultrasound (Routine Maternity)]  [See Maternity Enrollee/Spouse]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
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Affiliate Providers	Network Provider	Non-Network Provider
[Chiropractic Coverage Office Visit]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
[Chiropractic Coverage Other Services]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
[Chiropractic Coverage Diagnostic Testing]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Affiliate Providers	Network Provider	Non-Network Provider
<p><b>[Massotherapy]</b> <b>(Plan Approval Required)</b></p>	<p><u>You Must Pay:</u>  Deductible       [\$0-\$10,000]  Co-pay           [\$0-\$50]  Coinsurance     [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible       [\$0-\$15,000]  Co-pay           [\$0-\$50]  Coinsurance     [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [60-100%]  [After Annual Max 100%]</p>
<p><b>[Podiatry Coverage Office Visit]</b></p>	<p><u>You Must Pay:</u>  Deductible       [\$0-\$10,000]  Co-pay           [\$0-\$50]  Coinsurance     [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible       [\$0-\$15,000]  Co-pay           [\$0-\$50]  Coinsurance     [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [60-100%]  [After Annual Max 100%]</p>
<p><b>[Podiatry Coverage Diagnostic/Testing]</b></p>	<p><u>You Must Pay:</u>  Deductible       [\$0-\$10,000]  Co-pay           [\$0-\$50]  Coinsurance     [0-30%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [70-100%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible       [\$0-\$15,000]  Co-pay           [\$0-\$50]  Coinsurance     [0-40%UCR]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [60-100%]  [After Annual Max 100%]</p>

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

Affiliate Providers	Network Provider	Non-Network Provider
[Podiatry Coverage Surgery]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]
[Podiatry Coverage Other Services]	<u>You Must Pay:</u> Deductible [\$0-\$10,000] Co-pay [\$0-\$50] Coinsurance [0-30%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [70-100%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$0-\$15,000] Co-pay [\$0-\$50] Coinsurance [0-40%UCR] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [60-100%] [After Annual Max 100%]

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

\*Benefit level dependent upon where services rendered (see Page D, Annual Deductible, Coinsurance, and Out-of-Pocket Maximums). Benefits Not Listed are Not 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.

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