

# Health Care Benefit Chart

Issued & Underwritten by  
McKinley Life Insurance Company

**AULTAFFORD**



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.

\*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.

## BENEFITS CHART-TABLE OF CONTENTS

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

Your Eligibility Requirements .....	A
Your Waiting Period.....	A
Your Employer's Enrollment Periods.....	B
Your Coverage Ends .....	B
Your Dependent's Coverage Ends .....	C
Rehires.....	C
Maximum Time to Submit a Claim.....	C

### II. BENEFIT LEVELS UNDER THE GROUP POLICY BETWEEN YOUR EMPLOYER AND MCKINLEY LIFE INSURANCE COMPANY ..... D

Co-pay.....	D
Annual Deductible .....	D
Co-insurance (Out-of-Pocket Expense).....	D
Annual Out-of-Pocket Maximum.....	D
Lifetime Maximum .....	D
Penalty If You Do Not Get Pre-Approval .....	D

### III. COVERED SERVICES UNDER YOUR EMPLOYER'S GROUP POLICY ..... E

#### A. Inpatient, Outpatient, and Physician Office Care ..... E

Allergy Extract .....	E
Allergy Injections .....	E
Allergy Testing .....	E
Anesthesia .....	E
Bio-Feedback .....	F
Cardiac Rehabilitation I,II,III .....	G
Chemo/Radiation Therapy .....	G
Dialysis.....	H
Infertility Testing .....	I
Injections (Medical) .....	J
Inpatient Hospital Admission .....	K
Inpatient Hospital Physician .....	K
Laboratory/X-Ray/Diagnostic .....	L
Mammography (Medical Diagnosis) .....	L
Maternity .....	M
Occupational Therapy .....	N
Office Visit .....	N
Organ Donor Coverage .....	O
Organ Transplant Coverage.....	O
Physical Therapy.....	O
Pre-Admission Testing .....	P
Prescription Drugs Administered in Office.....	P
Rehabilitation Services.....	Q
Respiratory Therapy.....	Q

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Speech Therapy.....	R
Surgery.....	S
<b>B. Emergency and Urgent Care.....</b>	<b>U</b>
Emergency Care .....	U
Urgent Care.....	U
<b>C. Mental Health and Alcohol/Substance Abuse .....</b>	<b>W</b>
<b>D. Other Services .....</b>	<b>Y</b>
Abortion.....	Y
Ambulance .....	Y
Attention Deficit Disorder.....	Y
Blood Replacement Programs .....	Z
Breast Prosthesis/Bra.....	Z
Durable Medical Equipment .....	Z
Genetic Counseling .....	Z
Hepatitis Vaccination High Risk .....	AA
Home Health Care.....	AA
Hospice Care .....	AA
Pain Management .....	BB
Private Duty Nursing .....	BB
Psychological/Personality Testing.....	BB
Skilled Nursing .....	BB
Smoking Cessation.....	CC
Sterilization.....	CC
Temporomandibular Joint Dysfunction (TMJ).....	CC
<b>E. Educational Training .....</b>	<b>DD</b>
Diabetic Education .....	DD
Educational Training.....	DD
Nutritional Counseling.....	EE
<b>F. Preventive Care .....</b>	<b>FF</b>
Breast Reconstructive Surgery after Mastectomy .....	FF
Gynecological Exam.....	FF
Gynecological Pap Test .....	FF
Immunizations Beyond Well Child .....	GG
Mammography (Routine).....	GG
Physical (Routine) .....	GG
Ultrasound (Routine Maternity) .....	GG
Well Child Care .....	HH
<b>G. Affiliate Providers.....</b>	<b>II</b>
Chiropractic Coverage.....	II
Massotherapy.....	II
Podiatry Coverage.....	JJ

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## 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.

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## 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

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- e. Inpatient care no longer is Medically Necessary; or
- 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.

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**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.

<b>Policy Provision</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<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-\$75] [Primary Care Physician] [\$10-30] Specialist]	[\$0-\$75] [Primary Care Physician] [\$10-30] Specialist]
<b>Annual Deductible:</b> The minimum amount You must pay Out-of-Pocket each year before Benefits are paid under the Policy.	[\$250-\$500] for an individual [\$500-\$750] for a family	[\$750-\$1,000] for an individual [\$1,500-\$1,750] 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 Annual Deductible and Co-pay.	[Your share of the charge [0%-20%]]	[Your share of the charge [20%-50%] 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 and Coinsurance.	[\$900-\$1,200] per individual [\$1,800-\$2,500] per family  Once You have met this maximum, the Policy begins to pay covered medical expenses at 100% for the remainder of the year, up to the Annual Plan Maximum, except for penalties which are not included in the 100% reimbursement provision.	[\$2,500-\$2,750] per individual [\$5,000-\$5,500] per family  Once You have met this maximum, the Policy begins to pay covered medical expenses at 100% UCR for the remainder of the year, up to the Annual Plan Maximum, except for penalties 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. Annual maximum benefits apply year by year based on a Calendar Year. Subject to HIPAA and plan eligibility guidelines, you must have been insured on the plan through the end of the previous Calendar Year and continue to be insured under the plan on January 1 <sup>st</sup> of each subsequent Calendar Year in order to advance to the next Annual Maximum benefit level.	Year One = \$7,500 per individual Year Two = \$15,000 per individual Year Three = \$25,000 per individual Year Four [and after]= \$50,000 per individual [Year Five [and after]= \$100,000 per individual] [Year Six and after = \$1,000,000 per individual]	Year One = \$7,500 per individual Year Two = \$15,000 per individual Year Three = \$25,000 per individual Year Four [and after]= \$50,000 per individual [Year Five [and after] = \$100,000 per individual] [Year Six and after = \$1,000,000 per individual]
<b>Lifetime Maximum</b> [\$2,000 reinstatement]	[\$7,500 - \$5,000,000] [combined with Non-Network Lifetime Maximum]	[\$7,500 - \$5,000,000] [combined with Network Lifetime Maximum]
<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\***

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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
<b>Allergy Extract</b>	<p><u>You Must Pay:</u>  Deductible           [\$250-\$750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible           [\$750-\$1,750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-50%]  [After Annual Max 100%]</p>
<b>Allergy Injections</b>	<p><u>You Must Pay:</u>  Deductible           [\$250-\$750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible           [\$750-\$1,750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-50%]  [After Annual Max 100%]</p>
<b>Allergy Testing</b>  40 tests maximum per Calendar Year	<p><u>You Must Pay:</u>  Deductible           [\$250-\$750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible           [\$750-\$1,750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-50%]  [After Annual Max 100%]</p>
<b>Anesthesia In Office</b>	<p><u>You Must Pay:</u>  Deductible           [\$250-\$750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible           [\$750-\$1,750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-50%]  [After Annual Max 100%]</p>

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<b>Anesthesia Outpatient</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Anesthesia Inpatient</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Bio-Feedback In Office (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Bio-Feedback Outpatient (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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<b>Inpatient, Outpatient, and Physician Office Care</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Bio-Feedback Inpatient (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Cardiac Rehabilitation I &amp; II Outpatient</b>  <b>Cardiac Rehab III not covered</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Cardiac Rehabilitation I &amp; II Inpatient</b>  <b>Cardiac Rehab III not covered</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Chemo/Radiation Therapy In Office</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Chemo/Radiation Therapy Outpatient	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Chemo/Radiation Therapy Inpatient	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Dialysis In Office	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Dialysis Outpatient	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Dialysis Inpatient	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Infertility Testing In Office (Plan Approval Required)	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Infertility Testing Outpatient (Plan Approval Required)	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Infertility Testing Inpatient (Plan Approval Required)	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<b>Infertility Treatment Office Visit</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance   [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance   [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance   [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance   [100%-50%] [After Annual Max 100%]
<b>Infertility Treatment Outpatient</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance   [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance   [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance   [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance   [100%-50%] [After Annual Max 100%]
<b>Infertility Treatment Inpatient</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance   [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance   [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance   [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance   [100%-50%] [After Annual Max 100%]
<b>Injections (Medical) In Office (Plan Approval Required)</b>  <b>Not including routine Immunizations</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance   [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance   [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance   [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance   [100%-50%] [After Annual Max 100%]

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<b>Inpatient, Outpatient, and Physician Office Care</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Injections (Medical) Outpatient</b>  <b>Not including routine immunizations</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Injections (Medical) Inpatient</b>  <b>Not including routine immunizations</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Inpatient Hospital Admission (Semi-Private room)</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Inpatient Hospital Physician</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Laboratory/X-Ray/Diagnostic In Office	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Laboratory/X-Ray/Diagnostic Outpatient	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Laboratory/X-Ray/Diagnostic Inpatient	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Mammography (Medical Diagnosis) In Office	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<b>Mammography (Medical Diagnosis) Outpatient</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Mammography (Medical Diagnosis) Inpatient</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Maternity Enrollee/Spouse</b>  <b>Ultrasounds covered when Medically Necessary</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Maternity Dependent Care</b>  <b>The Dependent's Newborn coverage is not provided</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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<b>Inpatient, Outpatient, and Physician Office Care</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Occupational Therapy In Office</b>  <b>Illness or Injury Related</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Occupational Therapy Outpatient</b>  <b>Illness or Injury Related</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Occupational Therapy Inpatient</b>  <b>Illness or Injury Related</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Office Visit Illness</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Office Visit Injury	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Organ Donor Coverage	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Organ Transplant Coverage (Plan Approval Required)	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
Physical Therapy In Office Illness or Injury Related	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<b>Physical Therapy Outpatient Illness or Injury Related</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]
<b>Physical Therapy Inpatient Illness or Injury Related</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]
<b>Pre-Admission Testing</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]
<b>Prescription Drugs Administered in Office</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<b>Rehabilitation Services In Office</b>  <b>Illness or Injury Related</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Rehabilitation Services Outpatient</b>  <b>Illness or Injury Related</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Rehabilitation Services Inpatient</b>  <b>Illness or Injury Related</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Respiratory Therapy In Office</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Respiratory Therapy Outpatient	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
Respiratory Therapy Inpatient	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
Speech Therapy In Office Illness or Injury Related	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
Speech Therapy Outpatient Illness or Injury Related	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<b>Speech Therapy</b> <b>Inpatient</b> <b>Illness or Injury Related</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Surgery</b> <b>In Office</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Surgery</b> <b>Outpatient (Sameday)</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Surgery</b> <b>Inpatient</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
<b>Surgery</b> <b>Assistant Surgeon</b> <b>Outpatient</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Surgery</b> <b>Assistant Surgeon</b> <b>Inpatient</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Surgery</b> <b>Cosmetic/Reconstructive</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Surgery</b> <b>Second Surgical Opinion</b>  [Maximum penalty of 50% to Enrollee up to \$500 for Non-Network Providers]  [Required for Septo-rhino, tenotomy, Reconstructive-cosmetic, vein surgeries]	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Emergency and Urgent Care	Network Provider	Non-Network Provider
<b>Emergency Care</b> <b>Approved Emergency</b> (See Definition of Emergency Services)	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Non-Emergency</b> (See Definition of Emergency Services)	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Emergency Care</b> <b>Out of Service Area</b>	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Urgent Care</b>	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]

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Emergency and Urgent Care	Network Provider	Non-Network Provider
<b>Urgent Care Non-Approved</b>	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance    [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance    [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance    [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance    [100%-50%] [After Annual Max 100%]

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Mental Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
<p><b>Mental Health Outpatient</b></p> <p>With Plan Approval, services are paid the same as treatment for other physical illness or injury.</p>	<p><u>You Must Pay:</u>  Deductible           [\$250-\$750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible           [\$750-\$1,750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-50%]  [After Annual Max 100%]</p>
<p><b>Mental Health Inpatient</b></p> <p>With Plan Approval, services are paid the same as treatment for other physical illness or injury.</p>	<p><u>You Must Pay:</u>  Deductible           [\$250-\$750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible           [\$750-\$1,750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-50%]  [After Annual Max 100%]</p>
<p><b>Mental Health Outpatient Treatment Programs</b></p> <p>With Plan Approval, services are paid the same as treatment for other physical illness or injury.</p>	<p><u>You Must Pay:</u>  Deductible           [\$250-\$750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible           [\$750-\$1,750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-50%]  [After Annual Max 100%]</p>

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Mental Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
<p><b>Alcohol/Substance Abuse Outpatient</b></p> <p>With Plan Approval, services are paid the same as treatment for other physical illness or injury.</p>	<p><u>You Must Pay:</u>  Deductible           [\$250-\$750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible           [\$750-\$1,750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-50%]  [After Annual Max 100%]</p>
<p><b>Alcohol/Substance Abuse Inpatient</b></p> <p>With Plan Approval, services are paid the same as treatment for other physical illness or injury.</p>	<p><u>You Must Pay:</u>  Deductible           [\$250-\$750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible           [\$750-\$1,750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-50%]  [After Annual Max 100%]</p>
<p><b>Alcohol/Substance Abuse Outpatient Treatment Programs</b></p> <p>With Plan Approval, services are paid the same as treatment for other physical illness or injury.</p>	<p><u>You Must Pay:</u>  Deductible           [\$250-\$750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible           [\$750-\$1,750]  Co-pay               [\$0-\$75]  Coinsurance       [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance       [100%-50%]  [After Annual Max 100%]</p>

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Other Services	Network Provider	Non-Network Provider
<b>Abortion Therapeutic</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Ambulance</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Attention Deficit Disorder (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>[Bariatric Surgery] (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]

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Other Services	Network Provider	Non-Network Provider
<b>Blood Replacement Programs (Blood not replaced)</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Breast Prosthesis/Bra Initial</b>  <b>Replacement prosthesis is covered if Medically Necessary</b>  <b>Replacement bra is covered</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Durable Medical Equipment (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Genetic Counseling (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible       [\$250-\$750] Co-pay           [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible       [\$750-\$1,750] Co-pay           [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]

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Other Services	Network Provider	Non-Network Provider
<b>[Growth Hormone Treatment]</b>	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Hepatitis Vaccination High Risk</b>	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Home Health Care (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]
<b>Hospice Care (Plan Approval Required) Up to 6 months Bereavement is covered Respite care, counseling and training for proper dietary needs is not covered</b>	<u>You Must Pay:</u> Deductible      [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance     [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible      [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance     [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance     [100%-50%] [After Annual Max 100%]

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Other Services	Network Provider	Non-Network Provider
<b>Pain Management (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Private Duty Nursing (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Psychological/Personality Testing</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75]  Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75]  Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Skilled Nursing (Plan Approval Required)  Up to [50] days per illness</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Other Services	Network Provider	Non-Network Provider
[Smoking Cessation]	<p><u>You Must Pay:</u>  Deductible       [\$250-\$750]  Co-pay           [\$0-\$75]  Coinsurance     [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible       [\$750-\$1,750]  Co-pay           [\$0-\$75]  Coinsurance     [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [100%-50%]  [After Annual Max 100%]</p>
<b>Sterilization</b>  Reversals are not a covered expense	<p><u>You Must Pay:</u>  Deductible       [\$250-\$750]  Co-pay           [\$0-\$75]  Coinsurance     [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible       [\$750-\$1,750]  Co-pay           [\$0-\$75]  Coinsurance     [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [100%-50%]  [After Annual Max 100%]</p>
[Temporomandibular Joint Dysfunction (TMJ)]	<p><u>You Must Pay:</u>  Deductible       [\$250-\$750]  Co-pay           [\$0-\$75]  Coinsurance     [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible       [\$750-\$1,750]  Co-pay           [\$0-\$75]  Coinsurance     [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [100%-50%]  [After Annual Max 100%]</p>

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<b>Educational Training</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Diabetic Education Outpatient (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]
<b>Diabetic Education Inpatient (Plan Approval Required)</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]
<b>Educational Training Outpatient  Medically Necessary</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]
<b>Educational Training Inpatient  Medically Necessary</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]

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Educational Training	Network Provider	Non-Network Provider
<p>[Nutritional Counseling Outpatient]</p> <p>Medically Necessary</p>	<p><u>You Must Pay:</u>  Deductible [\$250-\$750]  Co-pay [\$0-\$75]  Coinsurance [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$750-\$1,750]  Co-pay [\$0-\$75]  Coinsurance [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [100%-50%]  [After Annual Max 100%]</p>
<p>[Nutritional Counseling Inpatient]</p> <p>Medically Necessary</p>	<p><u>You Must Pay:</u>  Deductible [\$250-\$750]  Co-pay [\$0-\$75]  Coinsurance [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible [\$750-\$1,750]  Co-pay [\$0-\$75]  Coinsurance [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance [100%-50%]  [After Annual Max 100%]</p>

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Preventive Care	Network Provider	Non-Network Provider
Breast Reconstructive Surgery after Mastectomy	<u>You Must Pay:</u> Deductible [\$250-\$750] Co-pay [\$0-\$75] Coinsurance [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$750-\$1,750] Co-pay [\$0-\$75] Coinsurance [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [100%-50%] [After Annual Max 100%]
[Colonoscopy]	<u>You Must Pay:</u> Deductible [\$250-\$750] Co-pay [\$0-\$75] Coinsurance [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$750-\$1,750] Co-pay [\$0-\$75] Coinsurance [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [100%-50%] [After Annual Max 100%]
Gynecological Exam  [\$200] per Calendar Year combined Wellness Maximum, excluding pap and mammogram	<u>You Must Pay:</u> Deductible [\$250-\$750] Co-pay [\$0-\$75] Coinsurance [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$750-\$1,750] Co-pay [\$0-\$75] Coinsurance [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [100%-50%] [After Annual Max 100%]
Gynecological Pap Test	<u>You Must Pay:</u> Deductible [\$250-\$750] Co-pay [\$0-\$75] Coinsurance [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible [\$750-\$1,750] Co-pay [\$0-\$75] Coinsurance [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance [100%-50%] [After Annual Max 100%]

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Preventive Care	Network Provider	Non-Network Provider
<b>Immunizations Beyond Well Child Care</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Mammography (Routine Screening)</b>  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.	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Physical (Routine)</b>  [\$200] per Calendar Year combined Wellness Maximum, excluding pap and mammogram  Prostate exam included	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>[Ultrasound (Routine Maternity)]</b>  See Maternity Enrollee/Spouse	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Preventive Care	Network Provider	Non-Network Provider
<p>Well Child Care (Hearing Screening included for age 0-12 months, benefit not to exceed \$75)</p> <p>Including immunizations up to 12 months</p>	<p><u>You Must Pay:</u>  Deductible       [\$250-\$750]  Co-pay           [\$0-\$75]  Coinsurance     [0%-20%]  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [100%-80%]  [After Annual Max 100%]</p>	<p><u>You Must Pay:</u>  Deductible       [\$750-\$1,750]  Co-pay           [\$0-\$75]  Coinsurance     [0%-50%]UCR  [After Annual Max \$0]</p> <p><u>We Will Pay:</u>  Coinsurance     [100%-50%]  [After Annual Max 100%]</p>

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Affiliate Providers	Network Provider	Non-Network Provider
<b>Chiropractic Coverage Office Visit</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Chiropractic Coverage Other Services</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>Chiropractic Coverage Diagnostic Testing</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]
<b>[Massotherapy]  Massotherapist not a covered expense</b>	<u>You Must Pay:</u> Deductible           [\$250-\$750] Co-pay               [\$0-\$75] Coinsurance       [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible           [\$750-\$1,750] Co-pay               [\$0-\$75] Coinsurance       [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance       [100%-50%] [After Annual Max 100%]

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Affiliate Providers	Network Provider	Non-Network Provider
<b>Podiatry Coverage Office Visit</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]
<b>Podiatry Coverage Diagnostic/Testing</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]
<b>Podiatry Coverage Surgery</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]
<b>Podiatry Coverage Other Services</b>	<u>You Must Pay:</u> Deductible        [\$250-\$750] Co-pay            [\$0-\$75] Coinsurance      [0%-20%] [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-80%] [After Annual Max 100%]	<u>You Must Pay:</u> Deductible        [\$750-\$1,750] Co-pay            [\$0-\$75] Coinsurance      [0%-50%]UCR [After Annual Max \$0]  <u>We Will Pay:</u> Coinsurance      [100%-50%] [After Annual Max 100%]

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MLIC Benefits Chart 2009-AA-AC-2

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MLIC Benefits Chart 2009-AA-AC-2