2020
SILVER 2000, 3550 and 5400 Plans
SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS	Silver 2000* In Network	Silver 2000* Non Network	Silver 3550* In Network	Silver 3550* Non Network	Silver 5400* In Network	Silver 5400* Non Network
Calendar Year Deductible						
Employee	$2,000	$6,000	$3,550	$10,650	$5,400	$16,200
Family	$4,000	$12,000	$7,100	$21,300	$10,800	$32,400
Benefit Level	50%	40% UCR	70%	50% UCR	85%	65% UCR
Medical Out-of-Pocket Maximum						
Employee	$8,150	$24,450	$8,150	$24,450	$8,150	$24,450
Family	$16,300	$48,900	$16,300	$48,900	$16,300	$48,900
Annual Maximum	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED
Emergency Services	50%	50% UCR	70%	70% UCR	85%	85% UCR
Urgent Care	$75 Copayment	$75 Copayment UCR	$75 Copayment	$75 Copayment UCR	$75 Copayment	$75 Copayment UCR
Preventive Health Services As defined by the Affordable Care Act	100%	40% UCR	100%	50% UCR	100%	65% UCR
Maternity Care	50%	40% UCR	70%	50% UCR	85%	65% UCR
Inpatient Hospital Services	50%	40% UCR	70%	50% UCR	85%	65% UCR
Diagnostic Services (Labs, X-Rays)	50%	40% UCR	70%	50% UCR	85%	65% UCR
Outpatient Therapy Services	50%	40% UCR	70%	50% UCR	85%	65% UCR
Second Surgical Opinion	50%	40% UCR	70%	50% UCR	85%	65% UCR
Other Services (Refer to plan benefit chart)	50%	40% UCR	70%	50% UCR	85%	65% UCR
Ambulance	50%	50% UCR	70%	70% UCR	85%	85% UCR
Physician Office Visits						
Visits for Illness / Injury	$45 Copayment	40% UCR	$40 Copayment	50% UCR	$25 Copayment	65% UCR
Specialist Office Visits for Illness/Injury	$65 Copayment	40% UCR	$60 Copayment	50% UCR	$45 Copayment	65% UCR
Telemedicine	$45 Copayment	40% UCR	$40 Copayment	50% UCR	$25 Copayment	65% UCR
Prescription Drugs	4 Tier Formulary		4 Tier Formulary		4 Tier Formulary	

UCR stands for Usual, Customary, and Reasonable

Prescription Drugs with Marketplace Formulary	**Retail 1-34 day supply:**	**Mail Order 90 day supply:**
	Tier 1: $10 Copayment or 20%, greater of	Tier 1: $30 or 20%, greater of
	Tier 2: $20 Copayment or 30%, greater of	Tier 2: $55 or 25%, greater of
	Tier 3: $45 Copayment or 40%, greater of	Tier 3: $125 or 35%, greater of
	Tier 4: $50 Copayment or 50%, greater of	Tier 4: $150 or 50%, greater of

*Embedded Deductible. Each member of a family is looked upon as an individual in regard to the Deductible. Once a member reaches the single Deductible, Coinsurance will apply.

Deductible and Out-of-Pocket maximum are Non-Integrated. Therefore, Deductibles and Out-of-Pocket amounts met for Network Providers DO NOT apply to Deductible and Out-of-Pocket amounts met for Non-Network providers.

Pediatric Dental and Vision (up to age 19) are included in this plan. Refer to certificate for full benefit details. NOTE: If you have purchased a standalone dental plan and provided an attestation to AultCare regarding that plan, coverage for pediatric dental, including a dental check-up, will be provided through that dental plan.

Not all benefit descriptions, exclusions and limitations are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificates of Coverage and Benefit Chart.