



**Alternative 1500/80A
HSA Compatible
Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
<i>Employee</i>	\$1,500	\$4,500
<i>Family</i>	\$3,000	\$9,000
Medical Plan Out-of-Pocket Maximum		
<i>Employee</i>	\$4,150	\$12,450
<i>Family</i>	\$6,650	\$19,950
Physician Office Visits and Telemedicine		
<i>Illness/Injury</i>	80%	60% RBP
<i>Psychotherapy Office</i>	80%	60% RBP
Prescription Drugs		
	80%	
Preventive Health Services		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% RBP
Maternity Care		
	80%	60% RBP
Inpatient Hospital Services		
	80%	60% RBP
Emergency Services		
	100%	100% RBP
Urgent Care		
	80%	80% RBP
Diagnostic Services (Labs, X-rays)		
	80%	60% RBP
Outpatient Therapy Services		
	80%	60% RBP
Other Services (Refer to Summary Plan Description)		
	80%	60% RBP
Ambulance		
	80%	80% RBP
Annual Plan Maximum		
	UNLIMITED	UNLIMITED

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

Unembedded Deductible. Family Deductibles are per family; there is no per-person Deductible. Therefore, if you have family coverage, one or more persons must satisfy the family Deductible amount.

Appropriate Deductible must be satisfied before any benefit is paid except as noted.

The Medical Plan Out-of-Pocket Maximum amount includes the Deductible.

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

Not all benefit descriptions and exclusions are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificate of Coverage which will govern.

Contact AultCare
www.aultcare.com
330-363-6360
1-800-344-8858

This information is intended to provide a summary of products offered by AultCare.



**Alternative 1500/100A
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Medical Benefits	Network	Non-Network
Calendar Year Deductible		
<i>Employee</i>	\$1,500	\$4,500
<i>Family</i>	\$3,000	\$9,000
Medical Plan Out-of-Pocket Maximum		
<i>Employee</i>	\$1,500	\$9,000
<i>Family</i>	\$3,000	\$18,000
Physician Office Visits and Telemedicine		
<i>Illness/Injury</i>	100%	80% RBP
<i>Psychotherapy Office</i>	100%	80% RBP
Prescription Drugs		
	100%	
Preventive Health Services		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% RBP
Maternity Care		
	100%	80% RBP
Inpatient Hospital Services		
	100%	80% RBP
Emergency Services		
	100%	100% RBP
Urgent Care		
	100%	100% RBP
Diagnostic Services (Labs, X-rays)		
	100%	80% RBP
Outpatient Therapy Services		
	100%	80% RBP
Other Services (Refer to Summary Plan Description)		
	100%	80% RBP
Ambulance		
	100%	100% RBP
Annual Plan Maximum		
	UNLIMITED	UNLIMITED

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**Alternative 2000/80A
HSA Compatible
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Medical Benefits	Network	Non-Network
Calendar Year Deductible		
<i>Employee</i>	\$2,000	\$6,000
<i>Family</i>	\$4,000	\$12,000
Medical Plan Out-of-Pocket Maximum		
<i>Employee</i>	\$4,150	\$12,450
<i>Family</i>	\$6,650	\$19,950
Physician Office Visits and Telemedicine		
<i>Illness/Injury</i>	80%	60% RBP
<i>Psychotherapy Office</i>	80%	60% RBP
Prescription Drugs		
	80%	
Preventive Health Services		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% RBP
Maternity Care		
	80%	60% RBP
Inpatient Hospital Services		
	80%	60% RBP
Emergency Services		
	80%	80% RBP
Urgent Care		
	80%	80% RBP
Diagnostic Services (Labs, X-rays)		
	80%	60% RBP
Outpatient Therapy Services		
	80%	60% RBP
Other Services (Refer to Summary Plan Description)		
	80%	60% RBP
Ambulance		
	80%	80% RBP
Annual Plan Maximum		
	UNLIMITED	UNLIMITED

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Unembedded Deductible. Family Deductibles are per family; there is no per-person Deductible. Therefore, if you have family coverage, one or more persons must satisfy the family Deductible amount.

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Medical Benefits	Network	Non-Network
Calendar Year Deductible		
<i>Employee</i>	\$2,000	\$6,000
<i>Family</i>	\$4,000	\$12,000
Medical Plan Out-of-Pocket Maximum		
<i>Employee</i>	\$2,000	\$12,000
<i>Family</i>	\$4,000	\$24,000
Physician Office Visits and Telemedicine		
<i>Illness/Injury</i>	100%	80% RBP
<i>Psychotherapy Office</i>	100%	80% RBP
Prescription Drugs		
	100%	
Preventive Health Services		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% RBP
Maternity Care		
	100%	80% RBP
Inpatient Hospital Services		
	100%	80% RBP
Emergency Services		
	100%	100% RBP
Urgent Care		
	100%	100% RBP
Diagnostic Services (Labs, X-rays)		
	100%	80% RBP
Outpatient Therapy Services		
	100%	80% RBP
Other Services (Refer to Summary Plan Description)		
	100%	80% RBP
Ambulance		
	100%	100% RBP
Annual Plan Maximum		
	UNLIMITED	UNLIMITED

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Unembedded Deductible. Family Deductibles are per family; there is no per-person Deductible. Therefore, if you have family coverage, one or more persons must satisfy the family Deductible amount.

Appropriate Deductible must be satisfied before any benefit is paid except as noted.

The Medical Plan Out-of-Pocket Maximum amount includes the Deductible.

Deductible is waived for Network Preventive Health Services.

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**Alternative 2500A
HSA Compatible
Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
<i>Employee</i>	\$2,500	\$7,500
<i>Family</i>	\$5,000	\$15,000
Medical Plan Out-of-Pocket Maximum		
<i>Employee</i>	\$2,500	\$15,000
<i>Family</i>	\$5,000	\$30,000
Physician Office Visits and Telemedicine		
<i>Illness/Injury</i>	100%	80% RBP
<i>Psychotherapy Office</i>	100%	80% RBP
Prescription Drugs		
	100%	
Preventive Health Services		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% RBP
Maternity Care		
	100%	80% RBP
Inpatient Hospital Services		
	100%	80% RBP
Emergency Services		
	100%	100% RBP
Urgent Care		
	100%	100% RBP
Diagnostic Services (Labs, X-rays)		
	100%	80% RBP
Outpatient Therapy Services		
	100%	80% RBP
Other Services (Refer to Summary Plan Description)		
	100%	80% RBP
Ambulance		
	100%	100% RBP
Annual Plan Maximum		
	UNLIMITED	UNLIMITED

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

Unembedded Deductible. Family Deductibles are per family; there is no per-person Deductible. Therefore, if you have family coverage, one or more persons must satisfy the family Deductible amount.

Appropriate Deductible must be satisfied before any benefit is paid except as noted.

The Medical Plan Out-of-Pocket Maximum amount includes the Deductible.

Deductible is waived for Network Preventive Health Services.

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**Alternative 3000A
HSA Compatible
Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
<i>Employee</i>	\$3,000	\$9,000
<i>Family</i>	\$6,000	\$18,000
Medical Plan Out-of-Pocket Maximum		
<i>Employee</i>	\$3,000	\$18,000
<i>Family</i>	\$6,000	\$36,000
Physician Office Visits and Telemedicine		
<i>Illness/Injury</i>	100%	80% RBP
<i>Psychotherapy Office</i>	100%	80% RBP
Prescription Drugs		
	100%	
Preventive Health Services		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% RBP
Maternity Care		
	100%	80% RBP
Inpatient Hospital Services		
	100%	80% RBP
Emergency Services		
	100%	100% RBP
Urgent Care		
	100%	100% RBP
Diagnostic Services (Labs, X-rays)		
	100%	80% RBP
Outpatient Therapy Services		
	100%	80% RBP
Other Services (Refer to Summary Plan Description)		
	100%	80% RBP
Ambulance		
	100%	100% RBP
Annual Plan Maximum		
	UNLIMITED	UNLIMITED

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