



**Alternative 2800D
HSA Compatible
Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
<i>Employee</i>	\$2,800	\$8,400
<i>Family</i>	\$5,600	\$16,800
Medical Plan Out-of-Pocket Maximum		
<i>Employee</i>	\$2,800	\$16,800
<i>Family</i>	\$5,600	\$33,600
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.

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. The Out-of-Pocket maximum amounts include the Deductible.

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

The Out-of-Pocket maximum amounts include 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 5000D
HSA Compatible
Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
<i>Employee</i>	\$5,000	\$15,000
<i>Family</i>	\$10,000	\$30,000
Medical Plan Out-of-Pocket Maximum		
<i>Employee</i>	\$5,000	\$22,050
<i>Family</i>	\$10,000	\$44,100
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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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. The Out-of-Pocket maximum amounts include the Deductible.

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Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

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**Alternative 6650D
HSA Compatible
Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
<i>Employee</i>	\$6,650	\$19,950
<i>Family</i>	\$13,300	\$39,900
Medical Plan Out-of-Pocket Maximum		
<i>Employee</i>	\$6,650	\$22,050
<i>Family</i>	\$13,300	\$44,100
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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This information is intended to provide a summary of products offered by AultCare.



**Alternative Max Limit D Plan
HSA Compatible
Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
<i>Employee</i>	\$6,900	\$20,700
<i>Family</i>	\$13,800	\$41,400
Medical Plan Out-of-Pocket Maximum		
<i>Employee</i>	\$6,900	\$24,450
<i>Family</i>	\$13,800	\$48,900
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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