Gold 1000

Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,000	$3,000
Family	$2,000	$6,000
Out-of-Pocket Maximum		
Employee	$5,900	$28,350
Family	$11,800	$56,700
Physician Office Visits		
Illness/Injury	$25 Copayment	50% RBP
Telemedicine	$25 Copayment	50% RBP
Specialist Office Visits		
Illness/Injury	$45 Copayment	50% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	70%	50% RBP
Inpatient Hospital Services	70%	50% RBP
Emergency Services	70%	70% RBP
Urgent Care	$75 Copayment	$75 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	70%	50% RBP
Outpatient Therapy Services	70%	50% RBP
Other Services *(Refer to Summary Plan Description)*	70%	50% RBP
Ambulance	70%	70% 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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

The Out-of-Pocket Maximum amount includes the Deductible, Copayments and Coinsurance.

Deductible is waived for Network Preventive Health Services.

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 **certified** stand alone 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.

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.

This Plan follows the Marketplace Managed formulary

Prescription Drugs	**Retail** (34 Day Supply Unless Noted)	**Mail Order** (*90 day supply)*
Tier 1 - 1-60 day supply/Retail	$0 Copayment	$0 Copayment
Tier 2 - 1-34 day supply	$10 Copayment or 20%, greater of	$30 Copayment or 20%, greater of
Tier 2 - 1-60 day supply/Retail	$30 Copayment or 20%, greater of	
Tier 3	$20 Copayment or 30%, greater of	$55 Copayment or 25%, greater of
Tier 4	$45 Copayment or 40%, greater of	$125 Copayment or 35%, greater of
Tier 5 and 6 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 5	$10 Copayment or 20%, greater of	N/A
Tier 6	$50 Copayment or 50%, greater of	N/A

Tier Definitions

The medication tier may change due to new Drugs and Generic availability

Tier 1 is defined as Preventive Maintenance medications.
Tier 2 is defined as Preferred Generic medications.
Tier 3 is defined as Non-Preferred Generic and Preferred Brand medications.
Tier 4 is defined as Non-Preferred Generic & Non-Preferred Brand medications.
Tier 5 is defined as Preferred Generic Specialty medications.
Tier 6 is defined as Preferred Brand Specialty medications.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

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

AULTCARE

Gold 1200

Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,200	$3,600
Family	$2,400	$7,200
Out-of-Pocket Maximum		
Employee	$7,000	$28,350
Family	$14,000	$56,700
Physician Office Visits		
Illness/Injury	$20 Copayment	60% RBP
Telemedicine	$20 Copayment	60% RBP
Specialist Office Visits		
Illness/Injury	$40 Copayment	60% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	60% RBP
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	80%	80% RBP
Urgent Care	$75 Copayment	$75 Copayment 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.

Embedded Deductible. Each family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

The Out-of-Pocket Maximum amount includes the Deductible, Copayments and Coinsurance.

Deductible is waived for Network Preventive Health Services.

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 **certified** stand alone 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.

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1-800-344-8858

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

This Plan follows the Marketplace Managed formulary

Prescription Drugs	**Retail** (34 Day Supply Unless Noted)	**Mail Order** (*90 day supply)*
Tier 1 - 1-60 day supply/Retail	$0 Copayment	$0 Copayment
Tier 2 - 1-34 day supply	$10 Copayment or 20%, greater of	$30 Copayment or 20%, greater of
Tier 2 - 1-60 day supply/Retail	$30 Copayment or 20%, greater of	
Tier 3	$20 Copayment or 30%, greater of	$55 Copayment or 25%, greater of
Tier 4	$45 Copayment or 40%, greater of	$125 Copayment or 35%, greater of
Tier 5 and 6 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 5	$10 Copayment or 20%, greater of	N/A
Tier 6	$50 Copayment or 50%, greater of	N/A

Tier Definitions

The medication tier may change due to new Drugs and Generic availability

Tier 1 is defined as Preventive Maintenance medications.
Tier 2 is defined as Preferred Generic medications.
Tier 3 is defined as Non-Preferred Generic and Preferred Brand medications.
Tier 4 is defined as Non-Preferred Generic & Non-Preferred Brand medications.
Tier 5 is defined as Preferred Generic Specialty medications.
Tier 6 is defined as Preferred Brand Specialty medications.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

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

Gold 1800

Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,800	$5,400
Family	$3,600	$10,800
Out-of-Pocket Maximum		
Employee	$7,100	$28,350
Family	$14,200	$56,700
Physician Office Visits		
Illness/Injury	$20 Copayment	70% RBP
Telemedicine	$20 Copayment	70% RBP
Specialist Office Visits		
Illness/Injury	$40 Copayment	70% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	70% RBP
Maternity Care	90%	70% RBP
Inpatient Hospital Services	90%	70% RBP
Emergency Services	90%	90% RBP
Urgent Care	$75 Copayment	$75 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	90%	70% RBP
Outpatient Therapy Services	90%	70% RBP
Other Services *(Refer to Summary Plan Description)*	90%	70% RBP
Ambulance	90%	90% 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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

The Out-of-Pocket Maximum amount includes the Deductible, Copayments and Coinsurance.

Deductible is waived for Network Preventive Health Services.

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 **certified** stand alone 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.

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1-800-344-8858

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

This Plan follows the Marketplace Managed formulary

Prescription Drugs	**Retail** (34 Day Supply Unless Noted)	**Mail Order** (*90 day supply)*
Tier 1 - 1-60 day supply/Retail	$0 Copayment	$0 Copayment
Tier 2 - 1-34 day supply	$10 Copayment or 20%, greater of	$30 Copayment or 20%, greater of
Tier 2 - 1-60 day supply/Retail	$30 Copayment or 20%, greater of	
Tier 3	$20 Copayment or 30%, greater of	$55 Copayment or 25%, greater of
Tier 4	$45 Copayment or 40%, greater of	$125 Copayment or 35%, greater of
Tier 5 and 6 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 5	$10 Copayment or 20%, greater of	N/A
Tier 6	$50 Copayment or 50%, greater of	N/A

Tier Definitions

The medication tier may change due to new Drugs and Generic availability

Tier 1 is defined as Preventive Maintenance medications.
Tier 2 is defined as Preferred Generic medications.
Tier 3 is defined as Non-Preferred Generic and Preferred Brand medications.
Tier 4 is defined as Non-Preferred Generic & Non-Preferred Brand medications.
Tier 5 is defined as Preferred Generic Specialty medications.
Tier 6 is defined as Preferred Brand Specialty medications.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

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

Gold 2750 HSA

Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,750	$8,250
Family	$5,500	$16,500
Out-of-Pocket Maximum		
Employee	$2,750	$28,350
Family	$5,500	$56,700
Physician Office Visits		
Illness/Injury	100%	80% RBP
Telemedicine	100%	80% RBP
Specialist Office Visits		
Illness/Injury	100%	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	80% 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. Entire family deductible must be met before any plan payments are made for any individual family member.

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

The Out-of-Pocket Maximum amount includes the Deductible and Coinsurance.

Deductible is waived for Network Preventive Health Services.

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 **certified** stand alone 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.

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1-800-344-8858

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

This Plan follows the Marketplace Managed formulary

Prescription Drugs	**Retail** (34 Day Supply Unless Noted)	**Mail Order** (*90 day supply)*
Tier 1 - 1-60 day supply/Retail	$0 Copayment	$0 Copayment
Tier 2 - 1-60 day supply	100% Coinsurance	100% Coinsurance
Tier 3	100% Coinsurance	100% Coinsurance
Tier 4	100% Coinsurance	100% Coinsurance
Tier 5 and 6 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 5	100% Coinsurance	N/A
Tier 6	100% Coinsurance	N/A

Tier Definitions

The medication tier may change due to new Drugs and Generic availability

Tier 1 is defined as Preventive Maintenance medications.
Tier 2 is defined as Preferred Generic medications.
Tier 3 is defined as Non-Preferred Generic and Preferred Brand medications.
Tier 4 is defined as Non-Preferred Generic & Non-Preferred Brand medications.
Tier 5 is defined as Preferred Generic Specialty medications.
Tier 6 is defined as Preferred Brand Specialty medications.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

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

Gold 3150

Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$3,150	$9,450
Family	$6,300	$18,900
Out-of-Pocket Maximum		
Employee	$4,750	$28,350
Family	$9,500	$56,700
Physician Office Visits		
Illness/Injury	$10 Copayment	70% RBP
Telemedicine	$10 Copayment	70% RBP
Specialist Office Visits		
Illness/Injury	$30 Copayment	70% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	70% RBP
Maternity Care	90%	70% RBP
Inpatient Hospital Services	90%	70% RBP
Emergency Services	90%	90% RBP
Urgent Care	$75 Copayment	$75 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	90%	70% RBP
Outpatient Therapy Services	90%	70% RBP
Other Services *(Refer to Summary Plan Description)*	90%	70% RBP
Ambulance	90%	90% 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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

The Out-of-Pocket Maximum amount includes the Deductible, Copayments and Coinsurance.

Deductible is waived for Network Preventive Health Services.

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 **certified** stand alone 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.

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

This Plan follows the Marketplace Managed formulary

Prescription Drugs	**Retail** (34 Day Supply Unless Noted)	**Mail Order** (*90 day supply)*
Tier 1 - 1-60 day supply/Retail	$0 Copayment	$0 Copayment
Tier 2 - 1-34 day supply	$10 Copayment or 20%, greater of	$30 Copayment or 20%, greater of
Tier 2 - 1-60 day supply/Retail	$30 Copayment or 20%, greater of	
Tier 3	$20 Copayment or 30%, greater of	$55 Copayment or 25%, greater of
Tier 4	$45 Copayment or 40%, greater of	$125 Copayment or 35%, greater of
Tier 5 and 6 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 5	$10 Copayment or 20%, greater of	N/A
Tier 6	$50 Copayment or 50%, greater of	N/A

Tier Definitions

The medication tier may change due to new Drugs and Generic availability

Tier 1 is defined as Preventive Maintenance medications.
Tier 2 is defined as Preferred Generic medications.
Tier 3 is defined as Non-Preferred Generic and Preferred Brand medications.
Tier 4 is defined as Non-Preferred Generic & Non-Preferred Brand medications.
Tier 5 is defined as Preferred Generic Specialty medications.
Tier 6 is defined as Preferred Brand Specialty medications.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

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