



**Alternative 2800 F
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		
	See Reverse side	
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.

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

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

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

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.

Prescription Copayments apply after medical Deductible of \$2,800/individual or \$5,600/family is met.

Prescription Drugs	Retail	Mail Order (90 day supply)
<i>Tier 1 - 1-34 day supply</i>	\$10 Copayment	\$25 Copayment
<i>Tier 1 - 35-60 day supply</i>	\$20 Copayment	
<i>Tier 2</i>	\$30 Copayment	\$85 Copayment
<i>Tier 3</i>	\$60 Copayment or 50%, greater of	\$170 Copayment
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
<i>Tier 4</i>	\$10 Copayment or 20%, greater of	\$10 Copayment or 20%, greater of
<i>Tier 5</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<p><i>A thirty four (34) day supply is available at the retail pharmacy</i> <i>A sixty (60) day supply is available at the retail pharmacy for Tier 1</i> <i>A ninety (90) day supply may be obtained through the mail order program</i></p>		

No prescription Copayments after an additional prescription out-of-pocket of \$750/individual or \$1,500 family is met.

Tier Definitions

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

- 1st Tier is defined as Generic medications
- 2nd Tier is defined as Preferred Brand medications
- 3rd Tier is defined as Non-Preferred Brand medications
- 4th Tier is defined as Specialty Generic medications
- 5th Tier is defined as Specialty Brand medications

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



**Alternative 5000 F
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		
	See Reverse side	
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		
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The Medical Plan Out-of-Pocket Maximum amount includes the Deductible and Medical Plan Copayments and Coinsurance.

Deductible is waived for Network Preventive Health Services.

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Prescription Copayments apply after medical Deductible of \$5,000/individual or \$10,000/family is met.

Prescription Drugs	Retail	Mail Order (90 day supply)
<i>Tier 1 - 1-34 day supply</i>	\$10 Copayment	\$25 Copayment
<i>Tier 1 - 35-60 day supply</i>	\$20 Copayment	
<i>Tier 2</i>	\$30 Copayment	\$85 Copayment
<i>Tier 3</i>	\$60 Copayment or 50%, greater of	\$170 Copayment
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