Aulternative 1000/80B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,000	$3,000
Family	$2,000	$6,000
Medical Plan Out-of-Pocket Maximum		
Employee	$2,000	$6,000
Family	$4,000	$12,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$6,550	N/A
Family	$13,100	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	60% RBP
Psychotherapy Office	$25 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%	50% RBP
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 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 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 or Copayment must be satisfied before any benefit is paid except as noted.

Deductible Carryover. Individual amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

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 Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
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.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $6,550 per Covered Person or $13,100 per Family
Once You have met the Out of Pocket Maximum, You will have a $0.00 Copayment

Tier Definitions

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

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

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

Aulternative 1000/100B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,000	$3,000
Family	$2,000	$6,000
Medical Plan Out-of-Pocket Maximum		
Employee	$1,000	$6,000
Family	$2,000	$12,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$7,550	N/A
Family	$15,100	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Psychotherapy Office	$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment 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 or Copayment must be satisfied before any benefit is paid except as noted.

Deductible Carryover. Individual amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

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Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
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Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
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.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $7,550 per Covered Person or $15,100 per Family
Once You have met the Out of Pocket Maximum, You will have a $0.00 Copayment

Tier Definitions

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

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

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

Aulternative 1500/80B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,500	$4,500
Family	$3,000	$9,000
Medical Plan Out-of-Pocket Maximum		
Employee	$2,500	$7,500
Family	$5,000	$15,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$6,050	N/A
Family	$12,100	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	60% RBP
Psychotherapy Office	$25 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%	50% RBP
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 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 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 or Copayment must be satisfied before any benefit is paid except as noted.

Deductible Carryover. Individual amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

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Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
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.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $6,050 per Covered Person or $12,100 per Family
Once You have met the Out of Pocket Maximum, You will have a $0.00 Copayment

Tier Definitions

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

Tier 1 is defined as Preferred Generic medications.
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Tier 3 is defined as Non-Preferred Brand and Non-Preferred Generic medications.
Tier 4 is defined as Specialty Generic medications.
Tier 5 is defined as Specialty Brand medications.

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

Aulternative 1500/100B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,500	$4,500
Family	$3,000	$9,000
Medical Plan Out-of-Pocket Maximum		
Employee	$1,500	$9,000
Family	$3,000	$18,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$7,050	N/A
Family	$14,100	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Psychotherapy Office	$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment 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 or Copayment must be satisfied before any benefit is paid except as noted.

Deductible Carryover. Individual amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

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Prescription Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
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Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
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.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $7,050 per Covered Person or $14,100 per Family
Once You have met the Out of Pocket Maximum, You will have a $0.00 Copayment

Tier Definitions

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

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

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

Aulternative 2000/80B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,000	$6,000
Family	$4,000	$12,000
Medical Plan Out-of-Pocket Maximum		
Employee	$4,000	$12,000
Family	$8,000	$24,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$4,550	N/A
Family	$9,100	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	60% RBP
Psychotherapy Office	$25 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%	50% RBP
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 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 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 or Copayment must be satisfied before any benefit is paid except as noted.

Deductible Carryover. Individual amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

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Prescription Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
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.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $4,550 per Covered Person or $9,100 per Family
Once You have met the Out of Pocket Maximum, You will have a $0.00 Copayment

Tier Definitions

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

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

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

Aulternative 2000/100B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,000	$6,000
Family	$4,000	$12,000
Medical Plan Out-of-Pocket Maximum		
Employee	$2,000	$12,000
Family	$4,000	$24,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$6,550	N/A
Family	$13,100	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Psychotherapy Office	$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment 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 or Copayment must be satisfied before any benefit is paid except as noted.

Deductible Carryover. Individual amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

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

Prescription Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
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.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $6,550 per Covered Person or $13,100 per Family
Once You have met the Out of Pocket Maximum, You will have a $0.00 Copayment

Tier Definitions

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

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

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

Aulternative 2500B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,500	$7,500
Family	$5,000	$15,000
Medical Plan Out-of-Pocket Maximum		
Employee	$2,500	$15,000
Family	$5,000	$30,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$6,050	N/A
Family	$12,100	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Psychotherapy Office	$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment 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 or Copayment must be satisfied before any benefit is paid except as noted.

Deductible Carryover. Individual amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

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Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
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.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $6,050 per Covered Person or $12,100 per Family
Once You have met the Out of Pocket Maximum, You will have a $0.00 Copayment

Tier Definitions

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

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

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

Aulternative 5000B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$5,000	$15,000
Family	$10,000	$30,000
Medical Plan Out-of-Pocket Maximum		
Employee	$8,550	$25,650
Family	$17,100	$51,300
Prescription Drug Out-of-Pocket Maximum		
Employee	Integrated with Medical	
Family	Network Out-of-Pocket	
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Psychotherapy Office	$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment 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 or Copayment must be satisfied before any benefit is paid except as noted.

Deductible Carryover. Individual amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

Deductible is waived for Network Preventive Health Services.

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

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 Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
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.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

Tier Definitions

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

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

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

Aulternative 7150B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$7,150	$21,450
Family	$14,300	$42,900
Medical Plan Out-of-Pocket Maximum		
Employee	$8,550	$25,650
Family	$17,100	$51,300
Prescription Drug Out-of-Pocket Maximum		
Employee	Integrated with Medical	
Family	Network Out-of-Pocket	
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Psychotherapy Office	$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment 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 or Copayment must be satisfied before any benefit is paid except as noted.

Deductible Carryover. Individual amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

Deductible is waived for Network Preventive Health Services.

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

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.

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330-363-6360
1-800-344-8858

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

Prescription Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
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.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

Tier Definitions

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

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

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

Aulternative Max Limit B Plan
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$8,550	$22,650
Family	$17,100	$45,300
Medical Plan Out-of-Pocket Maximum		
Employee	$8,550	$25,650
Family	$17,100	$51,300
Prescription Drug Out-of-Pocket Maximum		
Employee	Integrated with Medical	
Family	Network Out-of-Pocket	
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Psychotherapy Office	$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment 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 or Copayment must be satisfied before any benefit is paid except as noted.

Deductible Carryover. Individual amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

Deductible is waived for Network Preventive Health Services.

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

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.

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330-363-6360
1-800-344-8858

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

Prescription Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
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.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

Tier Definitions

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

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

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