

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 Maxim	num	
Employee	\$2,000	\$6,000
Family	\$4,000	\$12,000
Prescription Drug Out-of-Pocket M	aximum Separate from	n Medical
Employee	\$6,550	N/A
Family	\$13,100	N/A
Physician Office Visits and Telemed	licine	-
Illness/Injury	\$25 Copayment	60% RBP
Psychotherapy Office	\$25 Copayment	60% RBP
	<i>+_0 00payee</i>	
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for	10070	50% (15)
additional information.		
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
	¢1EQ Consumant	¢1E0 Consument BBD
Emergency Services	\$150 Copayment	\$150 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services	2007	
(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 <u>DO NOT</u> 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



Prescription Drugs	Retail	Mail Order (90 day supply)	
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,	
1-34 day supply	greater of	greater of	
Tier 1 -	\$20 Copayment or 20%,		
35-60 day supply	greater of		
Tion 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,	
Tier 2	greater of	greater of (\$200 max)	
Tion 2	\$45 Copayment or 50%,	\$130 Copayment or 45%,	
Tier 3	greater of	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.		
Tion 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,	
Tier 4	greater of	greater of	
Tion 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
Tier 5	greater of	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.



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 Maxim	านm	
Employee	\$1,000	\$6,000
Family	\$2,000	\$12,000
Prescription Drug Out-of-Pocket M	laximum Separate from	n Medical
Employee	\$7,550	N/A
Family	\$15,100	N/A
Physician Office Visits and Teleme	dicine	
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.	100%	50% RBP
See www.healthcare.gov for	10070	50% RBF
additional information.		
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
	UNLIMITED	UNLIMITED

Deductible and Out-of-Pocket Maximum are Non-Integrated. Therefore, Deductible and Out-of-Pocket amounts met for Network Providers <u>DO NOT</u> 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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Retail	Mail Order (90 day supply)
\$10 Copayment or 20%,	\$25 Copayment or 20%,
greater of	greater of
\$20 Copayment or 20%,	
greater of	
\$30 Copayment or 30%,	\$85 Copayment or 25%,
greater of	greater of (\$200 max)
\$45 Copayment or 50%,	\$130 Copayment or 45%,
greater of	greater of (\$400 max)
y Network pharmacy. Limited to a	-
\$10 Copayment or 20%,	\$10 Copayment or 20%,
greater of	greater of
\$125 Copayment or 20%,	\$125 Copayment or 20%,
greater of	greater of
day supply is available at the retain	il pharmacy
oply is available at the retail pharm	nacy for Tier 1
ly may be obtained through the mo	ail order proaram
	\$10 Copayment or 20%, greater of \$20 Copayment or 20%, greater of \$30 Copayment or 30%, greater of \$45 Copayment or 50%, greater of \$45 Copayment or 50%, greater of \$45 Copayment or 20%, greater of \$10 Copayment or 20%, greater of \$125 Copayment or 20%, greater of

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.



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 Maxim	num	
Employee	\$2,500	\$7,500
Family	\$5,000	\$15,000
Prescription Drug Out-of-Pocket M	aximum Separate from	Medical
Employee	\$6,050	N/A
Family	\$12,100	N/A
Physician Office Visits and Teleme	dicine	
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.	1000/	
See www.healthcare.gov for	100%	50% RBP
additional information.		
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
		\$150 copayment hbi
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services	80%	60% RBP
(Labs, X-rays)	8076	00% NBP
Outpatient Therapy Services	80%	60% RBP
Other Services (Refer to	000/	
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 <u>DO NOT</u> apply to Deductible and Out-of-Pocket amounts met for Non-Network Providers.

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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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Prescription Drugs	Retail	Mail Order (90 day supply)	
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,	
1-34 day supply	greater of	greater of	
Tier 1 -	\$20 Copayment or 20%,		
35-60 day supply	greater of		
Tion 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,	
Tier 2	greater of	greater of (\$200 max)	
Tion 2	\$45 Copayment or 50%,	\$130 Copayment or 45%,	
Tier 3	greater of	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.		
Tion 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,	
Tier 4	greater of	greater of	
Tion 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
Tier 5	greater of	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.



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 Maxir	num	
Employee	\$1,500	\$9,000
Family	\$3,000	\$18,000
Prescription Drug Out-of-Pocket N	Naximum Separate from	n Medical
Employee	\$7,050	N/A
Family	\$14,100	N/A
Physician Office Visits and Teleme	dicine	
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	100%	50% RBP
additional information.		
Maternity Care	100%	80% RBP
, Inpatient Hospital Services	100%	80% RBP
inpatient Hospital Services	100%	00% RDP
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
	UNLIMITED	UNLIMITED

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

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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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Prescription Drugs	Retail	Mail Order (90 day supply)	
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,	
1-34 day supply	greater of	greater of	
Tier 1 -	\$20 Copayment or 20%,		
35-60 day supply	greater of		
Tion 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,	
Tier 2	greater of	greater of (\$200 max)	
Tion 2	\$45 Copayment or 50%,	\$130 Copayment or 45%,	
Tier 3	greater of	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.		
Tion 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,	
Tier 4	greater of	greater of	
Tion 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
Tier 5	greater of	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.



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 Maxim	านm	
Employee	\$4,000	\$12,000
Family	\$8,000	\$24,000
Prescription Drug Out-of-Pocket M	laximum Separate from	n Medical
Employee	\$4,550	N/A
Family	\$9,100	N/A
Physician Office Visits and Teleme	dicine	
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.	1000/	
See www.healthcare.gov for	100%	50% RBP
additional information.		
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
	\$150 copuşment	\$100 copdyment ho
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services	80%	60% RBP
(Labs, X-rays)	0070	
Outpatient Therapy Services	80%	60% RBP
Other Services (Refer to	000/	C00/ DDD
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 <u>DO NOT</u> apply to Deductible and Out-of-Pocket amounts met for Non-Network Providers.

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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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Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
ner z	greater of	greater of (\$200 max)
Tior 2	\$45 Copayment or 50%,	\$130 Copayment or 45%,
Tier 3	greater of	greater of (\$400 max)
	is required. Medications must be a type of the second second second second second second second second second s The second s	•
Tier 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,
	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
1101 5	greater of	greater of
A thirty four (34) day supply is available at the reta	il pharmacy
A sixty (60) day sו	pply is available at the retail pharm	nacy for Tier 1
A min atus (00) daus asun	nly may be obtained through the m	

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 Maxin	num	
Employee	\$2,000	\$12,000
Family	\$4,000	\$24,000
Prescription Drug Out-of-Pocket N	laximum Separate from	n Medical
Employee	\$6,550	N/A
Family	\$13,100	N/A
Physician Office Visits and Teleme	dicine	
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	100%	50% RBP
additional information.		
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	4000/	000/ 000
(Labs, X-rays)	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to	4000/	000/ 222
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 <u>DO NOT</u> 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 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,	
1-34 day supply	greater of	greater of	
Tier 1 -	\$20 Copayment or 20%,		
35-60 day supply	greater of		
Tion 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,	
Tier 2	greater of	greater of (\$200 max)	
Tion 2	\$45 Copayment or 50%,	\$130 Copayment or 45%,	
Tier 3	greater of	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.		
Tion 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,	
Tier 4	greater of	greater of	
Tion 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
Tier 5	greater of	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.



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 Maxir	num	
Employee	\$2,500	\$15,000
Family	\$5,000	\$30,000
Prescription Drug Out-of-Pocket N	Naximum Separate from	n Medical
Employee	\$6,050	N/A
Family	\$12,100	N/A
Physician Office Visits and Teleme	dicine	
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.	100%	50% RBP
See www.healthcare.gov for	100%	
additional information.		
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 Comises (Defente		
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 <u>DO NOT</u> apply to Deductible and Out-of-Pocket amounts met for Non-Network Providers.

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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



Prescription Drugs	Retail	Mail Order (90 day supply)	
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,	
1-34 day supply	greater of	greater of	
Tier 1 -	\$20 Copayment or 20%,		
35-60 day supply	greater of		
Tion 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,	
Tier 2	greater of	greater of (\$200 max)	
Tion 2	\$45 Copayment or 50%,	\$130 Copayment or 45%,	
Tier 3	greater of	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%,	\$10 Copayment or 20%,	
	greater of	greater of	
T ' F	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
Tier 5	greater of	greater of	
A thirty four (34) day	supply is available at the reta	il 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.



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 Maxim	um	
Employee	\$8,550	\$25,650
Family	\$17,100	\$51,300
Prescription Drug Out-of-Pocket Ma	aximum	
Employee		with Medical
Family	Network C	Out-of-Pocket
Physician Office Visits and Telemed	icine	
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.	100%	F00/ DDD
See www.healthcare.gov for	100%	50% RBP
additional information.		
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	100%	000/ 000
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 <u>DO NOT</u> 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



Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	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)
	is required. Medications must be y Network pharmacy. Limited to a	-
Tier 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,
ner 4	greater of	greater of
Tior F	\$125 Copayment or 20%,	\$125 Copayment or 20%,
Tier 5	greater of	greater of
A thirty four (34) day supply is available at the reta	il pharmacy
A sixty (60) day su	pply is available at the retail pharm	nacy for Tier 1
A ninety (90) day supi	oly may be obtained through the m	ail order proaram

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.



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 Maxim	um	
Employee	\$8,550	\$25,650
Family	\$17,100	\$51,300
Prescription Drug Out-of-Pocket Ma	aximum	
Employee		with Medical
Family	-	Out-of-Pocket
Physician Office Visits and Telemed	icine	
Illness/Injury	\$25 Copayment	80% RBP
Psychotherapy Office	\$25 Copayment	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		50% RBP
the Affordable Care Act.	100%	
See www.healthcare.gov for	20070	5070 1121
additional information.		
Maternity Care	100%	80% RBP
npatient Hospital Services	100%	80% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services	1000/	00% 000
(Labs, X-rays)	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to	100%	000/ 000
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 <u>DO NOT</u> 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



Prescription Drugs	Retail	Mail Order (90 day supply)	
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,	
1-34 day supply	greater of	greater of	
Tier 1 -	\$20 Copayment or 20%,		
35-60 day supply	greater of		
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,	
THET 2	greater of	greater of (\$200 max)	
Tier 3	\$45 Copayment or 50%,	\$130 Copayment or 45%,	
Ther 3	greater of	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%,	\$10 Copayment or 20%,	
	greater of	greater of	
Tior F	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
Tier 5	greater of	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.



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 Maxim	um	
Employee	\$8,550	\$25,650
Family	\$17,100	\$51,300
Prescription Drug Out-of-Pocket Ma	aximum	
Employee	Integrated with Medical	
Family	Network C	Out-of-Pocket
Physician Office Visits and Telemed	icine	
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	100%	50% RBP
additional information.		
Maternity Care	100%	80% RBP
	10070	00% (10)
Inpatient Hospital Services	100%	80% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBF
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services	100%	000/ 000
(Labs, X-rays)	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to	40004	000/ 555
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 <u>DO NOT</u> 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

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Prescription Drugs	Retail	Mail Order (90 day supply)	
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,	
1-34 day supply	greater of	greater of	
Tier 1 -	\$20 Copayment or 20%,		
35-60 day supply	greater of		
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,	
THET 2	greater of	greater of (\$200 max)	
Tier 3	\$45 Copayment or 50%,	\$130 Copayment or 45%,	
Ther 3	greater of	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%,	\$10 Copayment or 20%,	
	greater of	greater of	
Tior F	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
Tier 5	greater of	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.