High Option 90%
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$150	$450
Family	$300	$900
Medical Plan Out-of-Pocket Maximum		
Employee	$500	$1,500
Family	$1,000	$3,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$8,050	N/A
Family	$16,100	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	90%	80% RBP
Psychotherapy Office	90%	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	90%	80% RBP
Inpatient Hospital Services	90%	80% RBP
Emergency Services	$75 Copayment	$75 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	90%	80% RBP
Outpatient Therapy Services	90%	80% RBP
Other Services *(Refer to Summary Plan Description)*	90%	80% 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 $8,050 per Covered Person or $16,100 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.

80% Option II
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$300	$900
Family	$600	$1,800
Medical Plan Out-of-Pocket Maximum		
Employee	$1,300	$3,900
Family	$2,600	$7,800
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$7,250	N/A
Family	$14,500	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	80%	60% RBP
Psychotherapy Office	80%	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	$75 Copayment	$75 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 $7,250 per Covered Person or $14,500 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.

750 Plan
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$750	$2,250
Family	$1,500	$4,500
Medical Plan Out-of-Pocket Maximum		
Employee	$3,000	$9,000
Family	$6,000	$18,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$5,550	N/A
Family	$11,100	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%	60% RBP
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	$75 Copayment	$75 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 $5,550 per Covered Person or $11,100 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.

Group Purchasing Plan I
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$100	$300
Family	$300	$900
Medical Plan Out-of-Pocket Maximum		
Employee	$600	$1,800
Family	$1,500	$4,500
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$7,950	N/A
Family	$15,600	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$10 Copayment	65% RBP
OB/GYN	$5 Copayment	65% RBP
Psychotherapy Office	$10 Copayment	65% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	65% RBP
Maternity Care	90%	65% RBP
Inpatient Hospital Services	90%	65% RBP
Emergency Services	$75 Copayment	$75 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	90%	65% RBP
Outpatient Therapy Services	90%	65% RBP
Other Services *(Refer to Summary Plan Description)*	90%	65% 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 $7,950 per Covered Person or $15,600 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.

Group Purchasing Plan III
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$200	$600
Family	$400	$1,200
Medical Plan Out-of-Pocket Maximum		
Employee	$700	$2,100
Family	$1,400	$4,200
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$7,850	N/A
Family	$15,700	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$10 Copayment	70% RBP
Psychotherapy Office	$10 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	$75 Copayment	$75 Copayment RBP
Urgent Care	$50 Copayment	$50 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	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 $7,850 per Covered Person or $15,700 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.