



## SCHEDULE OF HEALTH INSURANCE BENEFITS

|  |                                  | **                    |                                  | *                     |                                  |                       | ALIH INSUKAI            |                      |  |
|--|----------------------------------|-----------------------|----------------------------------|-----------------------|----------------------------------|-----------------------|-------------------------|----------------------|--|
| MEDICAL BENEFITS   | Platinur                         |                       | Platinur                         |                       |                                  | n 1000**              | Platinum 1550 HSAs***   |                      |  |
| INIEDICAL BENEFITS   | Network                          | Non Network           | Network                          | Non Network           | Network                          | Non Network           | Network                 | Non Network          |  |
| Calendar Year Deductible<br>Employee<br>Family   | \$200<br>\$400                   | \$600<br>\$1,200      | \$500<br>\$1,000                 | \$1,500<br>\$3,000    | \$1,000<br>\$2,000               | \$3,000<br>\$6,000    | \$1,550<br>\$3,100      | \$4,650<br>\$9,300   |  |
| Benefit Level  | 90%*                             | 70%*RBP               | 80%*                             | 60%*RBP               | 100%*                            | 80%*RBP               | 100%*                   | 80%*RBP              |  |
| Medical Out-of-Pocket Maximum<br>Employee<br>Family  | \$1,500<br>\$3,000               | \$25,650<br>\$51,300  | \$1,300<br>\$2,600               | \$25,650<br>\$51,300  | \$1,000<br>\$2,000               | \$25,650<br>\$51,300  | \$1,550<br>\$3,100      | \$25,650<br>\$51,300 |  |
| Annual Maximum   | UNLIMITED                        | UNLIMITED             | UNLIMITED                        | UNLIMITED             | UNLIMITED                        | UNLIMITED             | UNLIMITED               | UNLIMITED            |  |
| Emergency Services   | 90%*                             | 90%*RBP               | 80%*                             | 80%*RBP               | 100%*                            | 100%*RBP              | 100%*                   | 100%*RBP             |  |
| Urgent Care  | \$75 Copayment                   | \$75 Copayment<br>RBP | \$75 Copayment                   | \$75 Copayment<br>RBP | \$75 Copayment                   | \$75 Copayment<br>RBP | 100%*                   | 100%*RBP             |  |
| Preventive Health Services As defined by the Affordable Care Act.  | 100%                             | 70%*RBP               | 100%                             | 60%*RBP               | 100%                             | 80%*RBP               | 100%                    | 80%*RBP              |  |
| Maternity Care   | 90%*                             | 70%*RBP               | 80%*                             | 60%*RBP               | 100%*                            | 80%*RBP               | 100%*                   | 80%*RBP              |  |
| Inpatient Hospital Services  | 90%*                             | 70%*RBP               | 80%*                             | 60%*RBP               | 100%*                            | 80%*RBP               | 100%*                   | 80%*RBP              |  |
| Diagnostic Services<br>(Labs, X-Rays)  | 90%*                             | 70%*RBP               | 80%*                             | 60%*RBP               | 100%*                            | 80%*RBP               | 100%*                   | 80%*RBP              |  |
| Outpatient Therapy Services  | 90%*                             | 70%*RBP               | 80%*                             | 60%*RBP               | 100%*                            | 80%*RBP               | 100%*                   | 80%*RBP              |  |
| Second Surgical Opinion  | 90%*                             | 70%*RBP               | 80%*                             | 60%*RBP               | 100%*                            | 80%*RBP               | 100%*                   | 80%*RBP              |  |
| Other Services Refer to plan benefit chart   | 90%*                             | 70%*RBP               | 80%*                             | 60%*RBP               | 100%*                            | 80%*RBP               | 100%*                   | 80%*RBP              |  |
| Ambulance  | 90%*                             | 90%*RBP               | 80%*                             | 80%*RBP               | 100%*                            | 100%*RBP              | 100%*                   | 100%*RBP             |  |
| Physician Office Visits and Telemedicine Visits for Illness / Injury Specialist Office Visits for Illness / Injury | \$20 Copayment<br>\$40 Copayment | 70%*RBP<br>70%*RBP    | \$20 Copayment<br>\$40 Copayment | 60%*RBP<br>60%*RBP    | \$20 Copayment<br>\$40 Copayment | 80%*RBP<br>80%*RBP    | 100%*<br>100%*          | 80%*RBP<br>80%*RBP   |  |
| Prescription Drugs   | 6 Tier Phai                      | macy Plan             | 6 Tier Phai                      | rmacy Plan            | 6 Tier Pha                       | rmacy Plan            | HDHP Pha                | rmacy Plan           |  |
| Prescription Drugs with Marketplace Formulary  |                                  | 6-Tier Pha            | rmacy Plan                       |                       |                                  |                       | l<br>HDHP Pharmacy Plar | 1                    |  |
|  | Ret                              | ail                   | Ma                               | il Order (90 Day Sup  | ply)                             |                       |                         |                      |  |
| Preventive Maintenance List (1-60 days/retail) - Tier 1  | \$0 Copa                         | '                     |                                  | \$0 Copayment         |                                  |                       | \$0 Copayment           |                      |  |
| Preferred Generic (1-34 days/retail) - Tier 2  | \$10 Copayment o                 |                       | \$30 Co                          | payment or 20%, gre   | eater of                         | 100%* Coinsurance     |                         |                      |  |
| Preferred Brand & Non-Preferred Generic (35-60 days/retail) - Tier 2   | \$30 Copayment o                 | , 0                   | A A                              | . 050                 |                                  |                       | 100%* Coinsurance       |                      |  |
| Non-Preferred Brand & Non-Preferred Generic - Tier 3   | \$20 Copayment o                 |                       |                                  | payment or 25%, gre   |                                  |                       | 100%* Coinsurance       |                      |  |
| Non-Preferred Brand and Non-Preferred Generic - Tier 4   | \$45 Copayment o                 |                       |                                  | opayment or 35%, gr   |                                  |                       | 100%* Coinsurance       |                      |  |
| Tier 5 and 6 - Prior Authorization is requi  | reu. iviedications i             | nust be obtained t    | inough an AuitCare               | contracted specia     | iity wetwork pharn               | iacy. Limited to a s  | ou day suppiy.          |                      |  |

<sup>\*</sup> After Deductible

100%\* Coinsurance

100%\* Coinsurance

\$10 Copayment or 20%, greater of

\$50 Copayment or 50%, greater of

Deductible and Out-of-Pocket maximum are Non-Integrated. Therefore, Deductibles and Out-of-Pocket amounts met for Network Providers DO NOT apply to Deductible and Out-of-Pocket for Non-Network providers. Attestation required for Platinum 1550 HSAs. Employer is required to contribute \$500/Single and \$1,000/Family annually to each enrolled Employee's account

Pediatric Dental and Vision (up to age 19) are included in this plan. Refer to certificate for full benefit details.

Preferred Generic Specialty - **Tier 5**Preferred Brand Specialty - **Tier 6** 

NOTE: If you have purchased a standalone dental plan and provided an attestation to AultCare regarding that plan, coverage for pediatric dental, including a dental check-up, will be provided through that dental plan.

Not all benefit descriptions, exclusions and limitations are included in this document. Complete benefit descriptions are contained in the AultCare Insurance Company Certificates of Coverage and Benefit Chart.

\$10 Copayment or 20%, greater of

\$50 Copayment or 50%, greater of

**RBP stands for Reference Based Pricing** 

<sup>\*\*</sup>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.

<sup>\*\*\*</sup> Unembedded Deductible. Family Deductibles are per family, there is no per-person Deductible. Therefore, if you have family coverage, one or more persons must satisfy the family deductible amount.



GOLD 2500 Plan, HSA Compatible SCHEDULE OF HEALTH INSURANCE BENEFITS

| Calendar Year Deductible         \$2,500         \$7,500           Employee         \$2,500         \$15,000           Samily         \$100%*         \$00%*RBP           Medical Out-of-Pocket Maximum         \$2,500         \$25,500           Employee         \$2,500         \$25,500           Family         \$5,000         \$51,300           Annual Maximum         UNILIMITED         UNILIMITED           Emergency Services         100%*         100%*RBP           Urgent Care         100%*         100%*RBP           Preventive Health Services         100%*         80%*RBP           As defined by the Affordable Care Act         100%*         80%*RBP           Impatient Hospital Services         100%*         80%*RBP           Unganostic Services         100%*         80%*RBP           Undustrient Therapy Services         100%*         80%*RBP           Outpatient Therapy Services         100%*         80%*RBP           Other Services         100%*   |  | <br><u> </u> | LE OI IILALI | IT INSONAINCE DEINEITIS |
|---|--|--------------|--------------|-------------------------|
| Calendar Year Deductible  |  | Gold 25      | 00 HSA**     |                         |
| Employee   \$2,500   \$7,500   \$8,000   \$15,000 | MEDICAL BENEFITS   | In Network   | Non Network  |                         |
| Medical Out-of-Pocket Maximum Employee Family S2,500 S51,300 Annual Maximum UNLIMITED UNLIMITED UNUMITED UNCHIMITED UNG* 100%** BP  Preventive Health Services As defined by the Affordable Care Act  Maternity Care Inpatient Hospital Services Inpatient Hospital Services (Labs, X-Rays) Outpatient Therapy Services Second Surgical Opinion Unumited Unumited Indicate Services Inpatient Hospital Ser  | Calendar Year Deductible<br>Employee<br>Family                       |              |              |                         |
| S2,500  | Benefit Level  | 100%*        | 80%*RBP      |                         |
| Emergency Services  Urgent Care  100%* 100%*RBP  100%*RB  | Medical Out-of-Pocket Maximum<br>Employee<br>Family                  |              |              |                         |
| Urgent Care    100%*   100%*RBP   | Annual Maximum   | UNLIMITED    | UNLIMITED    |                         |
| Preventive Health Services As defined by the Affordable Care Act  Maternity Care  Inpatient Hospital Services Inpa  | Emergency Services   | 100%*        | 100%*RBP     |                         |
| As defined by the Affordable Care Act  Maternity Care  Inpatient Hospital Services  Inpatient Hospital   | Urgent Care  | 100%*        | 100%*RBP     |                         |
| Inpatient Hospital Services Diagnostic Services (Labs, X-Rays) Outpatient Therapy Services Second Surgical Opinion  Other Services (Refer to plan benefit chart) Ambulance Physician Office Visits and Telemedicine Visits for Illness / Injury Specialist Office Visits for Illness / Injury Specialist Office Visits for Illness / Injury Tier 1 Preventive Maintenance List  100%* 80%*RBP  100%* 80%*RBP  100%* 80%*RBP  \$0.00 Copayment   | Preventive Health Services As defined by the Affordable Care Act     | 100%         | 80%*RBP      |                         |
| Diagnostic Services (Labs, X-Rays)  Outpatient Therapy Services  100%* 80%*RBP  Second Surgical Opinion  100%* 80%*RBP  Other Services (Refer to plan benefit chart)  Ambulance  Physician Office Visits and Telemedicine Visits for Illness / Injury Specialist Office Visits for Illness / Injury  Prescription Drugs -  Retail up to 60 day or Mail Order 90 day Supply  Retail up to 60 day or Mail Order 90 day Supply  100%* 80%*RBP  \$0.00 Copayment  | Maternity Care   |              |              |                         |
| (Labs, X-Rays)  Outpatient Therapy Services  100%* 80%*RBP  Other Services  (Refer to plan benefit chart)  Ambulance  Physician Office Visits and Telemedicine Visits for Illness / Injury Specialist Office Visits for Illness/Injury  Prescription Drugs -  Retail up to 60 day or Mail Order 90 day Supply  100%* 80%*RBP  \$0.00 Copayment  | Inpatient Hospital Services  | 100%*        | 80%*RBP      |                         |
| Second Surgical Opinion  Other Services (Refer to plan benefit chart) Ambulance  Physician Office Visits and Telemedicine Visits for Illness / Injury Specialist Office Visits for Illness/Injury  Prescription Drugs - Retail up to 60 day or Mail Order 90 day Supply  100%* 80%*RBP  100%* 80%*RBP  100%* 80%*RBP  100%* 80%*RBP  \$0.00 Copayment   | Diagnostic Services<br>(Labs, X-Rays)                                | 100%*        | 80%*RBP      |                         |
| Other Services (Refer to plan benefit chart) Ambulance Physician Office Visits and Telemedicine Visits for Illness / Injury Specialist Office Visits for Illness/Injury  Prescription Drugs - Retail up to 60 day or Mail Order 90 day Supply  100%* 80%*RBP  100%* 80%*RBP  100%* 80%*RBP  100%* 80%*RBP  100%* 80%*RBP  100%* 80%*RBP   | Outpatient Therapy Services  | 100%*        | 80%*RBP      |                         |
| (Refer to plan benefit chart)  Ambulance  Physician Office Visits and Telemedicine  Visits for Illness / Injury Specialist Office Visits for Illness/Injury  Prescription Drugs -  Retail up to 60 day or Mail Order 90 day Supply  I 100%* 80%*RBP  Tier 1  Preventive Maintenance List  \$0.00 Copayment  | Second Surgical Opinion  | 100%*        | 80%*RBP      |                         |
| Physician Office Visits and Telemedicine Visits for Illness / Injury Specialist Office Visits for Illness/Injury  Prescription Drugs - Retail up to 60 day or Mail Order 90 day Supply  Tier 1 Preventive Maintenance List  \$0.00 Copayment  | Other Services (Refer to plan benefit chart)                         | 100%*        | 80%*RBP      |                         |
| Visits for Illness / Injury Specialist Office Visits for Illness/Injury  Prescription Drugs - Retail up to 60 day or Mail Order 90 day Supply  Tier 1 Preventive Maintenance List  \$0.00 Copayment   | Ambulance  | 100%*        | 100%*RBP     |                         |
| Retail up to 60 day or Mail Order 90 day Supply  Preventive Maintenance List  \$0.00 Copayment  Preventive Maintenance List   |  |              |              |                         |
|   | Prescription Drugs - Retail up to 60 day or Mail Order 90 day Supply |              | \$0.00 Co    | payment                 |
|   | incluin up to oo day or iviali order 50 day Suppry                   |              | 100% Coi     | insurance               |

<sup>\*</sup> After Deductible

Deductible and Out-of-Pocket maximum are Non-Integrated. Therefore, Deductibles and Out-of-Pocket amounts met for Network Providers DO NOT apply to Deductible and Out-of-Pocket for Non-Network providers.

Pediatric Dental and Vision (up to age 19) are included in this plan. Refer to certificate for full benefit details.

NOTE: If you have purchased a standalone dental plan and provided an attestation to AultCare regarding that plan, coverage for pediatric dental, including a dental check-up, will be provided through that dental plan.

RBP stands for Reference Based Pricing

<sup>\*\*</sup>Unembedded Deductible. Family Deductibles are per family, there is no per-person Deductible. Therefore, if you have family coverage, one or more persons must satisfy the family Deductible amount.





## GOLD 850, 1050, 1650 and 2900 Plans SCHEDULE OF HEALTH INSURANCE BENEFITS

|  | Gold                           | 850**                 | Gold 1                                     | 050**                 |   | 1650**                |                    | 2900**                |
|--|--------------------------------|-----------------------|--|-----------------------|---|-----------------------|--------------------|-----------------------|
| MEDICAL BENEFITS   | In Network                     | Non Network           | In Network                                 | Non Network           | In Network  | Non Network           | In Network         | Non Network           |
| WEDICAL DENETITS   | III Network                    | NOIT NELWORK          | milletwork                                 | Non Network           | III IVELWOIK  | Non Network           | milletwork         | Non Network           |
| Calendar Year Deductible   |                                |                       |  |                       |   |                       |                    |                       |
| Employee   | \$850                          | \$2,550               | \$1,050                                    | \$3,150               | \$1,650   | \$4,950               | \$2,900            | \$8,700               |
| Family   | \$1,700                        | \$5,100               | \$2,100                                    | \$6,300               | \$3,300   | \$9,900               | \$5,800            | \$17,400              |
| Benefit Level  | 70%*                           | 50%*RBP               | 80%*                                       | 60%*RBP               | 90%*  | 70%*RBP               | 90%*               | 70%*RBP               |
| Medical Out-of-Pocket Maximum  |                                |                       |  |                       |   |                       |                    |                       |
| Employee   | \$5,600                        | \$25,650              | \$6,700                                    | \$25,650              | \$6,700   | \$25,650              | \$4,200            | \$25,650              |
| Family   | \$11,200                       | \$51,300              | \$13,400                                   | \$51,300              | \$13,400  | \$51,300              | \$8,400            | \$51,300              |
| Annual Maximum   | UNLIMITED                      | UNLIMITED             | UNLIMITED                                  | UNLIMITED             | UNLIMITED   | UNLIMITED             | UNLIMITED          | UNLIMITED             |
| Emergency Services   | 70%*                           | 70%*RBP               | 80%*                                       | 80%*RBP               | 90%*  | 90%*RBP               | 90%*               | 90%*RBP               |
| Urgent Care  | \$75 Copayment                 | \$75 Copayment<br>RBP | \$75 Copayment                             | \$75 Copayment<br>RBP | \$75 Copayment  | \$75 Copayment<br>RBP | \$75 Copayment     | \$75 Copayment<br>RBP |
| Preventive Health Services As defined by the Affordable Care Act   | 100%                           | 50%*RBP               | 100%                                       | 60%*RBP               | 100%  | 70%*RBP               | 100%               | 70%*RBP               |
| Maternity Care   | 70%*                           | 50%*RBP               | 80%*                                       | 60%*RBP               | 90%*  | 70%*RBP               | 90%*               | 70%*RBP               |
| Inpatient Hospital Services  | 70%*                           | 50%*RBP               | 80%*                                       | 60%*RBP               | 90%*  | 70%*RBP               | 90%*               | 70%*RBP               |
| Diagnostic Services<br>(Labs, X-Rays)  | 70%*                           | 50%*RBP               | 80%*                                       | 60%*RBP               | 90%*  | 70%*RBP               | 90%*               | 70%*RBP               |
| Outpatient Therapy Services  | 70%*                           | 50%*RBP               | 80%*                                       | 60%*RBP               | 90%*  | 70%*RBP               | 90%*               | 70%*RBP               |
| Second Surgical Opinion  | 70%*                           | 50%*RBP               | 80%*                                       | 60%*RBP               | 90%*  | 70%*RBP               | 90%*               | 70%*RBP               |
| Other Services   | 70%*                           | 50%*RBP               | 80%*                                       | 60%*RBP               | 90%*  | 70%*RBP               | 90%*               | 70%*RBP               |
| (Refer to plan benefit chart)  |                                |                       |  |                       |   |                       |                    |                       |
| Ambulance  | 70%*                           | 70%*RBP               | 80%*                                       | 80%*RBP               | 90%*  | 90%*RBP               | 90%*               | 90%*RBP               |
| Physician Office Visits and Telemedicine   |                                |                       |  |                       |   |                       |                    |                       |
| Visits for Illness / Injury  | \$25 Copayment                 | 50%*RBP               | \$20 Copayment                             | 60%*RBP               | \$20 Copayment  | 70%*RBP               | \$10 Copayment     | 70%*RBP               |
| Specialist Office Visits for Illness/Injury  | \$45 Copayment                 | 50%*RBP               | \$40 Copayment                             | 60%*RBP               | \$40 Copayment  | 70%*RBP               | \$30 Copayment     | 70%*RBP               |
| Prescription Drugs with Marketplace Formulary  |                                | 6                     | -Tier Pharmacy Pla                         | n                     |   |                       |                    |                       |
|  |                                |                       | Retail                                     |                       | •   | 0 Day Supply)         |                    |                       |
| Preventive Maintenance List (1-60 days/retail)- Tier 1   |                                |                       | opayment or Coinsur                        |                       | \$0 Copayment or Coinsurance  |                       |                    |                       |
| Preferred Generic (1-34 days/retail)- Tier 2   |                                |                       | payment or 20%, gre                        |                       | \$30 Copayment or 20%, greater of                                       |                       |                    |                       |
| Preferred Brand & Non-Preferred Generic (35-6  |                                |                       | payment or 20%, gre<br>payment or 30%, gre |                       | \$55 Consument or 3   | 25% greater of        |                    |                       |
| Non-Preferred Brand & Non-Preferred Generic- Tier 3  Non-Preferred Brand and Non-Preferred Generic- Tier 4 |                                |                       | payment or 30%, gre                        |                       | \$55 Copayment or 25%, greater of<br>\$125 Copayment or 35%, greater of |                       |                    |                       |
| Tier 5 and 6 - Prior Authorization is rec  |                                |                       |  |                       |   |                       | o a 30 day supply  |                       |
|  | neric Specialty- <b>Tier 5</b> |                       | payment or 20%, gre                        |                       | \$10 Copayment or 2   |                       | o a 30 day supply. |                       |
|  | 16 : 1: -: 6                   | ¢E0.C=                |  |                       | CEO Community on F  | 00/                   |                    |                       |

<sup>\*</sup> After Deductible

\$50 Copayment or 50%, greater of

Preferred Brand Specialty - Tier 6

Deductible and Out-of-Pocket maximum are Non-Integrated. Therefore, Deductibles and Out-of-Pocket amounts met for Network Providers DO NOT apply to Deductible and Out-of-Pocket for Non-Network providers.

Pediatric Dental and Vision (up to age 19) are included in this plan. Refer to certificate for full benefit details.

NOTE: If you have purchased a standalone dental plan and provided an attestation to AultCare regarding that plan, coverage for pediatric dental, including a dental check-up, will be provided through that dental plan.

Not all benefit descriptions, exclusions and limitations are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificates of Coverage and Benefit Chart.

\$50 Copayment or 50%, greater of

**RBP stands for Reference Based Pricing** 

<sup>\*\*</sup>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.



2021
SILVER 2400 and 4250 Plans, HSA Compatible
SCHEDULE OF HEALTH INSURANCE BENEFITS

|  |                               |                     | 00 HSA***            |  |                    | \$12,750<br>\$25,500<br>\$0%*RBP<br>\$25,650<br>\$51,300<br>UNLIMITED<br>100%*RBP<br>100%*RBP<br>80%*RBP<br>80%*RBP<br>80%*RBP<br>80%*RBP |  |
|--|-------------------------------|---------------------|----------------------|--|--------------------|---|--|
| MEDICAL BENEFITS   |                               | In Network          | Non Network          |  | In Network         | Non Network   |  |
| Calendar Year Deductible<br>Employee<br>Family   |                               | \$2,400<br>\$4,800  | \$7,200<br>\$14,400  |  | \$4,250<br>\$8,500 |   |  |
| Benefit Level  |                               | 80%*                | 60%*RBP              |  | 100%*              | 80%*RBP   |  |
| Medical Out of Pocket Maximum<br>Employee<br>Family  |                               | \$7,000<br>\$14,000 | \$25,650<br>\$51,300 |  | \$4,250<br>\$8,500 |   |  |
| Annual Maximum   |                               | UNLIMITED           | UNLIMITED            |  | UNLIMITED          | UNLIMITED   |  |
| Emergency Services   |                               | 80%*                | 80%* RBP             |  | 100%*              | 100%*RBP  |  |
| Urgent Care  |                               | 80%*                | 80%* RBP             |  | 100%*              | 100%*RBP  |  |
| Preventice Health Services As defined by the Affordable Care Act   |                               | 100%                | 60%*RBP              |  | 100%               | 80%*RBP   |  |
| Maternity Care   |                               | 80*%                | 60%* RBP             |  | 100%*              | 80%*RBP   |  |
| Inpatient Hospital Services  |                               | 80%*                | 60%*RBP              |  | 100%*              | 80%*RBP   |  |
| Diagnostic Services<br>(Labs, X-Rays)  |                               | 80%*                | 60%* RBP             |  | 100%*              | 80%* RBP  |  |
| Outpatient Therapy Services  |                               | 80%*                | 60%*RBP              |  | 100%*              | 80%*RBP   |  |
| Second Surgical Opinion  |                               | 80*%                | 60%* RBP             |  | 100%*              | 80%* RBP  |  |
| Other Services (Refer to plan benefit chart)   |                               | 80*%                | 60%* RBP             |  | 100%*              | 80%* RBP  |  |
| Ambulance  |                               | 80%*                | 80%*RBP              |  | 100%*              | 100%* RBP   |  |
| Physician Office Visits and Telemedicine<br>Visits for Illness/Injury<br>Specialist Office Visits for Illness / Injury |                               | 80*%<br>80*%        | 60%* RBP<br>60%* RBP |  | 100%*<br>100%*     | 80%* RBP<br>80%* RBP  |  |
| Prescription Drugs -<br>Retail up to 60 day or Mail Order 90 day Supply  | Tier 1 Preventive Maintenance | \$0 Co              | payment              |  | \$0 Cop            | payment   |  |
|  | Tier 2 - Tier 6               | 80% Co              | insurance            |  | 100% Co            | pinsurance  |  |

<sup>\*</sup> After Deductible

**RBP stands for Reference Based Pricing** 

Deductible and Out-of-Pocket maximum are Non-Integrated. Therefore, Deductibles and Out-of-Pocket amounts met for Network Providers DO NOT apply to Deductible and Out-of-Pocket for Non-Network providers.

Pediatric Dental and Vision (up to age 19) are included in this plan. Refer to certificate for full benefit details.

NOTE: If you have purchased a standalone dental plan and provided an attestation to AultCare regarding that plan, coverage for pediatric dental, including a dental check-up, will be provided through that dental plan.

<sup>\*\*</sup>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.

<sup>\*\*\*</sup> Unembedded Deductible. Family Deductibles are per family, there is no per-person Deductible. Therefore, if you have family coverage, one or more persons must satisfy the family deductible amount.



## 2021 SILVER 2000, 3550 AND 5400 Plans SCHEDULE OF HEALTH INSURANCE BENEFITS

|  | Silver         | 2000**                | Silver         | r 3550**              |  | Silver 5400**  |                       |
|--|----------------|-----------------------|----------------|-----------------------|--|----------------|-----------------------|
| MEDICAL BENEFITS   | In Network     | Non Network           | In Network     | Non Network           |  | In Network     | Non Network           |
| Calendar Year Deductible   |                |                       |                |                       |  |                |                       |
| Employee   | \$2,000        | \$6,000               | \$3,550        | \$10,650              |  | \$5,400        | \$16,200              |
| Family   | \$4,000        | \$12,000              | \$7,100        | \$21,300              |  | \$10,800       | \$32,400              |
| Benefit Level  | 50%*           | 40%*RBP               | 70%*           | 50%*RBP               |  | 85%*           | 65%*RBP               |
| Medical Out-of-Pocket Maximum                                    |                |                       |                |                       |  |                |                       |
| Employee   | \$8,550        | \$25,650              | \$8,550        | \$25,650              |  | \$8,550        | \$25,650              |
| Family   | \$17,100       | \$51,300              | \$17,100       | \$51,300              |  | \$17,100       | \$51,300              |
| Annual Maximum   | UNLIMITED      | UNLIMITED             | UNLIMITED      | UNLIMITED             |  | UNLIMITED      | UNLIMITED             |
| Emergency Services   | 50%*           | 50%*RBP               | 70%*           | 70%*RBP               |  | 85%*           | 85% RBP               |
| Urgent Care  | \$75 Copayment | \$75 Copayment<br>RBP | \$75 Copayment | \$75 Copayment<br>RBP |  | \$75 Copayment | \$75 Copayment<br>RBP |
| Preventive Health Services As defined by the Affordable Care Act | 100%           | 40%*RBP               | 100%           | 50%*RBP               |  | 100%           | 65%*RBP               |
| Maternity Care   | 50%*           | 40%*RBP               | 70%*           | 50%*RBP               |  | 85%*           | 65%*RBP               |
| Inpatient Hospital Services                                      | 50%*           | 40%*RBP               | 70%*           | 50%*RBP               |  | 85%*           | 65%*RBP               |
| Diagnostic Services<br>(Labs, X-Rays)                            | 50%*           | 40%*RBP               | 70%*           | 50%*RBP               |  | 85%*           | 65%*RBP               |
| Outpatient Therapy Services                                      | 50%*           | 40%*RBP               | 70%*           | 50%*RBP               |  | 85%*           | 65%*RBP               |
| Second Surgical Opinion  | 50%*           | 40%*RBP               | 70%*           | 50%*RBP               |  | 85%*           | 65%*RBP               |
| Other Services   | 50%*           | 40%*RBP               | 70%*           | 50%*RBP               |  | 85%*           | 65%*RBP               |
| (Refer to plan benefit chart)                                    |                |                       |                |                       |  |                |                       |
| Ambulance  | 50%*           | 50%*RBP               | 70%*           | 70%*RBP               |  | 85%*           | 85% RBP               |
|  |                |                       |                |                       |  |                |                       |
| Physician Office Visits and Telemedicine                         |                |                       |                |                       |  |                |                       |
| Visits for Illness / Injury                                      | \$45 Copayment | 40%*RBP               | \$40 Copayment | 50%*RBP               |  | \$25 Copayment | 65%*RBP               |
| Specialist Office Visits for Illness/Injury                      | \$65 Copayment | 40%*RBP               | \$60 Copayment | 50%*RBP               |  | \$45 Copayment | 65%*RBP               |

| rescription Drugs with Marketplace Formulary 6-Tier Pharmacy Plan       |   |   |
|---|---|---|
|   | Retail  | Mail Order (90 Day Supply)                |
| Preventive Maintenance List (1-60 days/retail) - Tier 1                 | \$0 Copayment   | \$0 Copayment                             |
| Preferred Generic (1-34 days/retail) - <b>Tier 2</b>                    | \$10 Copayment or 20%, greater of                     | \$30 Copayment or 20%, greater of         |
| Preferred Brand & Non-Preferred Generic (35-60 days/retail) - Tier 2    | \$30 Copayment or 20%, greater of                     |   |
| Non-Preferred Brand & Non-Preferred Generic - Tier 3                    | \$20 Copayment or 30%, greater of                     | \$55 Copayment or 25%, greater of         |
| Non-Preferred Brand and Non-Preferred Generic - Tier 4                  | \$45 Copayment or 40%, greater of                     | \$125 Copayment or 35%, greater of        |
| Tier 5 and 6 - Prior Authorization is required. Medications must be obt | tained through an AultCare contracted Specialty Netwo | ork pharmacy. Limited to a 30 day supply. |
| Preferred Generic Specialty - <b>Tier 5</b>                             | \$10 Copayment or 20%, greater of                     | \$10 Copayment or 20%, greater of         |
| Preferred Brand Specialty - <b>Tier 6</b>                               | \$50 Copayment or 50%, greater of                     | \$50 Copayment or 50%, greater of         |

<sup>\*</sup> After Deductible

**RBP stands for Reference Based Pricing** 

Deductible and Out-of-Pocket maximum are Non-Integrated. Therefore, Deductibles and Out-of-Pocket amounts met for Network Providers DO NOT apply to Deductible and Out-of-Pocket for Non-Network

Pediatric Dental and Vision (up to age 19) are included in this plan. Refer to certificate for full benefit details.

NOTE: If you have purchased a standalone dental plan and provided an attestation to AultCare regarding that plan, coverage for pediatric dental, including a dental check-up, will be provided through that dental plan.

<sup>\*\*</sup>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.



## BRONZE 5400 and 6850 Plans, HSA Compatible SCHEDULE OF HEALTH INSURANCE BENEFITS

|  |                                      | Bronze              | 5400**               | Bronze              | 6850**               |  |
|--|--------------------------------------|---------------------|----------------------|---------------------|----------------------|--|
| MEDICAL BENEFITS   |                                      | In Network          | Non Network          | In Network          | Non Network          |  |
| <b>Calendar Year Deductible</b><br>Employee<br>Family  |                                      | \$5,400<br>\$10,800 | \$16,200<br>\$32,400 | \$6,850<br>\$13,700 | \$20,550<br>\$41,100 |  |
| Benefit Level  |                                      | 50%*                | 40%*RBP              | 100%*               | 80%*RBP              |  |
| <b>Medical Out-of-Pocket Maximum</b><br>Employee<br>Family   |                                      | \$7,000<br>\$14,000 | \$25,650<br>\$51,300 | \$6,850<br>\$13,700 | \$25,650<br>\$51,300 |  |
| Annual Maximum   |                                      | UNLIMITED           | UNLIMITED            | UNLIMITED           | UNLIMITED            |  |
| Emergency Services   |                                      | 50%*                | 50%*RBP              | 100%*               | 100%*RBP             |  |
| Urgent Care  |                                      | 50%*                | 50%*RBP              | 100%*               | 100%*RBP             |  |
| Preventive Health Services As defined by the Affordable Care Act   |                                      | 100%                | 40%*RBP              | 100%                | 80%*RBP              |  |
| Maternity Care   |                                      | 50%*                | 40%*RBP              | 100%*               | 80%*RBP              |  |
| Inpatient Hospital Services  |                                      | 50%*                | 40%*RBP              | 100%*               | 80%*RBP              |  |
| Diagnostic Services<br>(Labs, X-Rays)  |                                      | 50%*                | 40%*RBP              | 100%*               | 80%*RBP              |  |
| Outpatient Therapy Services  |                                      | 50%*                | 40%*RBP              | 100%*               | 80%*RBP              |  |
| Second Surgical Opinion  |                                      | 50%*                | 40%*RBP              | 100%*               | 80%*RBP              |  |
| Other Services (Refer to plan benefit chart)   |                                      | 50%*                | 40%*RBP              | 100%*               | 80%*RBP              |  |
| Ambulance  |                                      | 50%*                | 50% RBP              | 100%*               | 100%*RBP             |  |
| Physician Office Visits and Telemedicine Visits for Illness / Injury Specialist Office Visits for Illness/Injury |                                      | 50%*<br>50%*        | 40%*RBP<br>40%*RBP   | 100%*<br>100%*      | 80%*RBP<br>80%*RBP   |  |
| Prescription Drugs -<br>Retail up to 60 day or Mail Order 90 day Supply  | <b>Tier 1</b> Preventive Maintenance | \$0.00 Copayment    |                      | \$0.00 Cd           | ppayment             |  |
|  | Tier 2 - Tier 6                      | 50% Coi             | nsurance             | 100% Co             | insurance            |  |

<sup>\*</sup> After Deductible RBP stands for Reference Based Pricing

Deductible and Out-of-Pocket maximum are Non-Integrated. Therefore, Deductibles and Out-of-Pocket amounts met for Network Providers DO NOT apply to Deductible and Out-of-Pocket for Non-Network providers.

Pediatric Dental and Vision (up to age 19) are included in this plan. Refer to certificate for full benefit details.

NOTE: If you have purchased a standalone dental plan and provided an attestation to AultCare regarding that plan, coverage for pediatric dental, including a dental check-up, will be provided through that dental plan.

<sup>\*\*</sup>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.