AULTCARE

2021

PLATINUM 200, 500 1000 & 1550 PLANS
SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS	Platinum 200**		Platinum 500**		Platinum 1000**		Platinum 1550 HSAs***	
	Network	Non Network	Network	Non Network	Network	Non Network	Network	Non Network
Calendar Year Deductible								
Employee	$200	$600	$500	$1,500	$1,000	$3,000	$1,550	$4,650
Family	$400	$1,200	$1,000	$3,000	$2,000	$6,000	$3,100	$9,300
Benefit Level	90%*	70%*RBP	80%*	60%*RBP	100%*	80%*RBP	100%*	80%*RBP
Medical Out-of-Pocket Maximum								
Employee	$1,500	$25,650	$1,300	$25,650	$1,000	$25,650	$1,550	$25,650
Family	$3,000	$51,300	$2,600	$51,300	$2,000	$51,300	$3,100	$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 RBP	$75 Copayment	$75 Copayment RBP	$75 Copayment	$75 Copayment 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 (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	$20 Copayment	70%*RBP	$20 Copayment	60%*RBP	$20 Copayment	80%*RBP	100%*	80%*RBP
Specialist Office Visits for Illness / Injury	$40 Copayment	70%*RBP	$40 Copayment	60%*RBP	$40 Copayment	80%*RBP	100%*	80%*RBP
Prescription Drugs	6 Tier Pharmacy Plan		6 Tier Pharmacy Plan		6 Tier Pharmacy Plan		HDHP Pharmacy Plan	

Prescription Drugs with Marketplace Formulary	**6-Tier Pharmacy Plan**		**HDHP Pharmacy Plan**
	Retail	**Mail Order (90 Day Supply)**	
Preventive Maintenance List (1-60 days/retail) - **Tier 1**	$0 Copayment	$0 Copayment	$0 Copayment
Preferred Generic (1-34 days/retail) - **Tier 2**	$10 Copayment or 20%, greater of	$30 Copayment or 20%, greater of	100%* Coinsurance
Preferred Brand & Non-Preferred Generic (35-60 days/retail) - **Tier 2**	$30 Copayment or 20%, greater of		100%* Coinsurance
Non-Preferred Brand & Non-Preferred Generic - **Tier 3**	$20 Copayment or 30%, greater of	$55 Copayment or 25%, greater of	100%* Coinsurance
Non-Preferred Brand and Non-Preferred Generic - **Tier 4**	$45 Copayment or 40%, greater of	$125 Copayment or 35%, greater of	100%* Coinsurance
Tier 5 and 6 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.			
Preferred Generic Specialty - **Tier 5**	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of	100%* Coinsurance
Preferred Brand Specialty - **Tier 6**	$50 Copayment or 50%, greater of	$50 Copayment or 50%, greater of	100%* Coinsurance

*** After Deductible**

RBP stands for Reference Based Pricing

****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.**

***** 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.**

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.
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.

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AULTCARE

2021

GOLD 2500 Plan, HSA Compatible

SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS		Gold 2500 HSA** In Network	Non Network
Calendar Year Deductible			
Employee		$2,500	$7,500
Family		$5,000	$15,000
Benefit Level		100%*	80%*RBP
Medical Out-of-Pocket Maximum			
Employee		$2,500	$25,560
Family		$5,000	$51,300
Annual Maximum		UNLIMITED	UNLIMITED
Emergency Services		100%*	100%*RBP
Urgent Care		100%*	100%*RBP
Preventive Health Services As defined by the Affordable Care Act		100%	80%*RBP
Maternity Care			
Inpatient Hospital Services		100%*	80%*RBP
Diagnostic Services (Labs, X-Rays)		100%*	80%*RBP
Outpatient Therapy Services		100%*	80%*RBP
Second Surgical Opinion		100%*	80%*RBP
Other Services (Refer to plan benefit chart)		100%*	80%*RBP
Ambulance		100%*	100%*RBP
Physician Office Visits and Telemedicine			
Visits for Illness / Injury		100%*	80%*RBP
Specialist Office Visits for Illness/Injury		100%*	80%*RBP
Prescription Drugs - Retail up to 60 day or Mail Order 90 day Supply	**Tier 1** Preventive Maintenance List	$0.00 Copayment	
	Tier 2 - Tier 6	100% Coinsurance	

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****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.**

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.

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AULTCARE

2021

GOLD 850, 1050, 1650 and 2900 Plans

SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS	Gold 850** In Network	Gold 850** Non Network	Gold 1050** In Network	Gold 1050** Non Network	Gold 1650** In Network	Gold 1650** Non Network	Gold 2900** In Network	Gold 2900** 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 RBP	$75 Copayment	$75 Copayment RBP	$75 Copayment	$75 Copayment RBP	$75 Copayment	$75 Copayment 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 (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 (Refer to plan benefit chart)	70%*	50%*RBP	80%*	60%*RBP	90%*	70%*RBP	90%*	70%*RBP
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 Plan**	
	Retail	**Mail Order (90 Day Supply)**
Preventive Maintenance List (1-60 days/retail)- **Tier 1**	$0 Copayment or Coinsurance	$0 Copayment or Coinsurance
Preferred Generic (1-34 days/retail)- **Tier 2**	$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 obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Preferred Generic Specialty- **Tier 5**	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Preferred Brand Specialty - **Tier 6**	$50 Copayment or 50%, greater of	$50 Copayment or 50%, greater of

*** After Deductible**

RBP stands for Reference Based Pricing

****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.**

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.

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AULTCARE

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

MEDICAL BENEFITS		Silver 2400 HSA*** In Network	Silver 2400 HSA*** Non Network	Silver 4250 HSA** In Network	Silver 4250 HSA** Non Network
Calendar Year Deductible					
Employee		$2,400	$7,200	$4,250	$12,750
Family		$4,800	$14,400	$8,500	$25,500
Benefit Level		80%*	60%*RBP	100%*	80%*RBP
Medical Out of Pocket Maximum					
Employee		$7,000	$25,650	$4,250	$25,650
Family		$14,000	$51,300	$8,500	$51,300
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 (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					
Visits for Illness/Injury		80*%	60%* RBP	100%*	80%* RBP
Specialist Office Visits for Illness / Injury		80*%	60%* RBP	100%*	80%* RBP
Prescription Drugs - Retail up to 60 day or Mail Order 90 day Supply	**Tier 1** Preventive Maintenance	$0 Copayment		$0 Copayment	
	Tier 2 - Tier 6	80% Coinsurance		100% Coinsurance	

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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.

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AULTCARE

2021

SILVER 2000, 3550 AND 5400 Plans

SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS	Silver 2000** In Network	Silver 2000** Non Network	Silver 3550** In Network	Silver 3550** Non Network	Silver 5400** In Network	Silver 5400** 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 RBP	$75 Copayment	$75 Copayment RBP	$75 Copayment	$75 Copayment 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 (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 (Refer to plan benefit chart)	50%*	40%*RBP	70%*	50%*RBP	85%*	65%*RBP
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

Prescription 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) - **Tier 2**	$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 obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Preferred Generic Specialty - **Tier 5**	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Preferred Brand Specialty - **Tier 6**	$50 Copayment or 50%, greater of	$50 Copayment or 50%, greater of

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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.

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AULTCARE

2021

BRONZE 5400 and 6850 Plans, HSA Compatible

SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS		Bronze 5400** In Network	Bronze 5400** Non Network	Bronze 6850** In Network	Bronze 6850** Non Network
Calendar Year Deductible					
Employee		$5,400	$16,200	$6,850	$20,550
Family		$10,800	$32,400	$13,700	$41,100
Benefit Level		50%*	40%*RBP	100%*	80%*RBP
Medical Out-of-Pocket Maximum					
Employee		$7,000	$25,650	$6,850	$25,650
Family		$14,000	$51,300	$13,700	$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 (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		50%*	40%*RBP	100%*	80%*RBP
Specialist Office Visits for Illness/Injury		50%*	40%*RBP	100%*	80%*RBP
Prescription Drugs - Retail up to 60 day or Mail Order 90 day Supply	**Tier 1** Preventive Maintenance	$0.00 Copayment		$0.00 Copayment	
	Tier 2 - Tier 6	50% Coinsurance		100% Coinsurance	

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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.

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