

Platinum 200 **Schedule of Health Insurance Benefits**

Network	Non-Network	Deductible and Maximum are N
		Therefore, Dedu
4000	4600	Pocket amounts
	· · · · · · · · · · · · · · · · · · ·	Providers DO NO
\$400	\$1,200	Deductible and amounts met fo
m		Providers.
\$1,500	\$25,650	Embedded Ded
\$3,000	\$51,300	member of a far
		as an individual
cine		Deductible. Once
\$20 Copayment	70% RBP	will apply.
		Appropriate De
	70% RBP	satisfied before
1 7		except as noted
See Reverse side		The Medical Pla
		Maximum amou
		Deductible, Cop
		Prescription Co
4000/	70% RBP	Coinsurance.
100%		Deductible is w
		Preventive Hea
90%	70% RRD	Pediatric Denta
3070	7 0 70 NDF	age 19) are inclu
90%	70% RBP	Refer to certific details.
3070	7 0 70 1101	details.
90%	90% RBP	Note: If you have
	2 0/2 11.01	certificed stand
\$75 Copayment	\$75 Copayment RBP	and provided arAultCare regard
,,	,	coerage for ped
		including a dent
90%	70% RBP	provided throug
000/	700/ 555	Not all benefit o
90%	/0% RBP	exclusions and included in this
1		Complete benej
90%	70% RBP	exclusions are c
		AultCare Insura
90%	90% RBP	Certificates of C Chart.
UNLIMITED	UNLIMITED	Contact AultCar
	\$3,000 cine \$20 Copayment cine \$40 Copayment 100% 90% 90% 90% \$75 Copayment 90% 90% 90% 90% 90%	\$400 \$1,200 m \$1,500 \$25,650 \$3,000 cine \$20 Copayment 70% RBP cine \$40 Copayment 70% RBP See Reverse side 100% 70% RBP 90% 70% RBP 90% 70% RBP \$75 Copayment \$75 Copayment RBP 90% 70% RBP 90% 70% RBP

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tible and Out-ofmet for Network **T** apply to ut-of-Pocket Non-Network

ctible. Each ily is looked upon n regard to the a member reaches ible, Coinsurance

uctible must be ny benefit is paid

Out-of-Pocket t includes the yments, yments and

ved for Network h Services.

and Vision (up to led in this plan. te for full benefit

purchased a one dental plan attestation to ng that plan, tric dental, check-up, will be that dental plan.

scriptions, nitations are ocument. descriptions and ntained in the ce Company verage and Benefit



Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1	\$0.00 Copayment	\$0.00 Copayment
Tier 2 -	\$10 Copayment or 20%,	\$30 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 2 -	\$30 Copayment or 20%,	
35-60 day supply	greater of	
Tier 3	\$20 Copayment or 30%,	\$55 Copayment or 25%,
	greater of	greater of
-	\$45 Copayment or 40%,	\$125 Copayment or 35%,
Tier 4	greater of	greater of
Tier 5 and 6 - Prior Authorization is requi	red. Medications must be obtain	ned through an AultCare contracted
Specialty Netw	ork pharmacy. Limited to a 30 d	day supply.
Tier 5	\$10 Copayment or 20%,	\$10 Copayment or 20%,
	greater of	greater of
Tier 6	\$50 Copayment or 50%,	\$50 Copayment or 50%,
	greater of	greater of
A thirty four (34)	day supply is available at the ret	ail pharmacy
A sixty (60) day supply is	available at the retail pharmacy	for Tier 1 and Tier 2
A ninety (90) day suppl	y may be obtained through the n	nail order program

- **Tier 1** is defined as Preventive Maintenance List medications.
- **Tier 2** is defined as Preferred Generic medications.
- *Tier 3* is defined as Preferred Brand and Non-Preferred Generic medications.
- *Tier 4* is defined as Non-Preferred Brand and Non-Preferred Generic medications.
- *Tier 5* is defined as Preferred Generic Specialty medications.
- *Tier 6* is defined as Preferred Brand Specialty medications.



Platinum 500 **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network	Deductible and Maximum are N
Calendar Year Deductible			Therefore, Dedu
Employee	\$500	\$1,500	Providers DO N
Family	\$1,000	\$3,000	Deductible and
,,	+ -) = 0 = 0	φο,σσσ	amounts met fo
Medical Plan Out-of-Pocket Maximu	m		Providers.
Employee	\$1,300	\$25,650	Embedded Ded
Family	\$2,600	\$51,300	member of a fa
			as an individual
Physician Office Visits and Telemedi			Deductible. One the single Dedu
Illness/Injury	\$20 Copayment	60% RBP	will apply.
Specialist Office Visits and Telemedi	cine		Appropriate De
Illness/Injury	\$40 Copayment	60% RBP	satisfied before
iiiicss, iiijai y	y to copayment	00% NB1	except as noted
Prescription Drugs	See Reverse side		The Medical Pla
			Maximum amou
Preventive Health Services			Deductible, Cop
As defined by			Prescription Co
the Affordable Care Act.	1000/	C00/ DDD	Coinsurance.
See www.healthcare.gov for	100%	60% RBP	Deductible is w
additional information.			Preventive Hea
Maternity Care	80%	60% RBP	Pediatric Denta
Materinty Care	00%	00% KBP	age 19) are inclu
Inpatient Hospital Services	80%	60% RBP	Refer to certific details.
- Approximate of the control of the		3377.1161	details.
Emergency Services	80%	80% RBP	Note: If you hav
			certificed stand
Urgent Care	\$75 Copayment	\$75 Copayment RBP	and provided arAultCare regard
<u> </u>			coerage for ped
Diagnostic Services	000/	C00/ DDD	including a dent
(Labs, X-rays)	80%	60% RBP	provided throug
Outmations Thereas Committee	000/	C00/ BBB	Not all benefit o
Outpatient Therapy Services	80%	60% RBP	exclusions and l
Other Services (Refer to			Complete benef
Summary Plan Description)	80%	60% RBP	exclusions are c
2			AultCare Insura
Ambulance	80%	80% RBP	Certificates of C Chart.
Annual Plan Maximum	UNLIMITED	UNLIMITED	Contact AultCar
			www.aultcare.c

d Out-of-Pocket Non-Integrated.

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uctible. Each mily is looked upon in regard to the ce a member reaches ctible, Coinsurance

ductible must be any benefit is paid

n Out-of-Pocket unt includes the ayments, payments and

aived for Network Ith Services.

and Vision (up to uded in this plan. ate for full benefit

e purchased a alone dental plan attestation to ing that plan, iatric dental, tal check-up, will be gh that dental plan.

descriptions, imitations are document. fit descriptions and ontained in the nce Company overage and Benefit

re om



Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1	\$0.00 Copayment	\$0.00 Copayment
Tier 2 -	\$10 Copayment or 20%,	\$30 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 2 -	\$30 Copayment or 20%,	
35-60 day supply	greater of	
Tier 3	\$20 Copayment or 30%,	\$55 Copayment or 25%,
Her 3	greater of	greater of
Tier 4	\$45 Copayment or 40%,	\$125 Copayment or 35%,
ner 4	greater of	greater of
Tier 5 and 6 - Prior Authorization is requ	uired. Medications must be obtain	ned through an AultCare contracted
Specialty Net	work pharmacy. Limited to a 30 a	lay supply.
Tion F	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Tier 5	greater of	greater of
Tier 6	\$50 Copayment or 50%,	\$50 Copayment or 50%,
	greater of	greater of
A thirty four (34	l) day supply is available at the ret	ail pharmacy
A sixty (60) day supply	is available at the retail pharmacy	for Tier 1 and Tier 2
A ninety (90) day sup	ply may be obtained through the n	nail order program

- *Tier 1* is defined as Preventive Maintenance List medications.
- Tier 2 is defined as Preferred Generic medications.
- *Tier 3* is defined as Preferred Brand and Non-Preferred Generic medications.
- *Tier 4* is defined as Non-Preferred Brand and Non-Preferred Generic medications.
- Tier 5 is defined as Preferred Generic Specialty medications.
- *Tier 6* is defined as Preferred Brand Specialty medications.



Platinum 1000

Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$1,000	\$3,000
Family	\$2,000	\$6,000
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Medical Plan Out-of-Pocket Maximเ	ım	
Employee	\$1,000	\$25,650
Family	\$2,000	\$51,300
Dhysisian Office Visits and Talamad	iain a	
Physician Office Visits and Telemedi		900/ DDD
Illness/Injury	\$20 Copayment	80% RBP
Specialist Office Visits and Telemed	icine	
Illness/Injury	\$40 Copayment	80% RBP
	· ·	
Prescription Drugs	See Reverse side	
Preventive Health Services	1	
As defined by		
the Affordable Care Act.	100%	80% RBP
See www.healthcare.gov for		33732.
additional information.		
Maternity Care	100%	80% RBP
waterinty care	100/0	0070 NDI
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	\$75 Copayment	\$75 Copayment RBP
Diagnostic Services	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to	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 must be satisfied before any benefit is paid except as noted.

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

Deductible is waived for Network Preventive Health Services.

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 certificed standalone dental plan and provided an attestation to AultCare regarding that plan, coerage 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.

Contact AultCare

www.aultcare.com 330-363-6360 1-800-344-8858



Prescription Drugs	Retail	Mail Order (90 day supply)	
Tier 1	\$0.00 Copayment	\$0.00 Copayment	
Tier 2 -	\$10 Copayment or 20%,	\$30 Copayment or 20%,	
1-34 day supply	greater of	greater of	
Tier 2 -	\$30 Copayment or 20%,		
35-60 day supply	greater of		
Tion 2	\$20 Copayment or 30%,	\$55 Copayment or 25%,	
Tier 3	greater of	greater of	
Tier 4	\$45 Copayment or 40%,	\$125 Copayment or 35%,	
Tier 4	greater of	greater of	
Tier 5 and 6 - Prior Authorization is required	tion is required. Medications must be obtained through an AultCare contracted		
Specialty Network pharmacy. Limited to a 30 day supply.			
Tier 5	\$10 Copayment or 20%,	\$10 Copayment or 20%,	
	greater of	greater of	
Tier 6	\$50 Copayment or 50%,	\$50 Copayment or 50%,	
	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 and Tier 2			
A ninety (90) day supply may be obtained through the mail order program			

- *Tier 1* is defined as Preventive Maintenance List medications.
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- *Tier 5* is defined as Preferred Generic Specialty medications.
- Tier 6 is defined as Preferred Brand Specialty medications.



Platinum 1550 HSA 500 Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$1,550	\$4,650
Family	\$3,100	\$9,300
Medical Plan Out-of-Pocket Maximu	m	
Employee	\$1,550	\$25,650
Family	\$3,100	\$51,300
Physician Office Visits and Telemedi	rine	
Illness/Injury	100%	80% RBP
Specialist Office Visits and Telemedi	cine	
Illness/Injury	100%	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.		
See www.healthcare.gov for	100%	80% RBP
additional information.		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services	100%	000/ 000
(Labs, X-rays)	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to	100%	80% RBP
Summary Plan Description)	100/0	0U/0 KDY
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.

Unembedded Deductible. Family Deductibles are per family, there is no per-person Deductible. Therefor, if you have family coverage, one or more persons must satisfy the family Deductible amount.

Appropriate Deductible must be satisfied before any benefit is paid except as noted.

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

Deductible is waived for Network Preventive Health Services.

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 certificed standalone dental plan and provided an attestation to AultCare regarding that plan, coerage 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.

Contact AultCare



rescription Drugs	Retail	Mail Order (90 day supply)
Tier 1	\$0.00 Copayment	\$0.00 Copayment
Tier 2 - 1-34 day supply	100% Coinsurance	100% Coinsurance
Tier 2 - 35-60 day supply	100% Coinsurance	
Tier 3	100% Coinsurance	100% Coinsurance
Tier 4	100% Coinsurance	100% Coinsurance
Tier 5 and 6 - Prior Authorization is contracted Specialty	s required. Medications must be y Network pharmacy. Limited to	
Tier 5	100% Coinsurance	100% Coinsurance
Tier 6	100% Coinsurance	100% Coinsurance
) day supply is available at the ret s available at the retail pharmacy	· ·

A ninety (90) day supply may be obtained through the mail order program

- *Tier 1* is defined as Preventive Maintenance List medications.
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- *Tier 4* is defined as Non-Preferred Brand and Non-Preferred Generic medications.
- *Tier 5* is defined as Preferred Generic Specialty medications.
- *Tier 6* is defined as Preferred Brand Specialty medications.