90% High Option Plan
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$150	$300
Family	$300	$600
Out-of-Pocket Maximum		
Employee	$500	$1,000
Family	$1,000	$2,000
Physician Office Visits and Telemedicine		
For Illness	90%	80% UCR
For Injury	100%	100% UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	80% UCR
Maternity Care	90%	80% UCR
Inpatient Hospital Services	90%	80% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services *(Labs, X-rays)*	90%	80% UCR
Outpatient Therapy Services	90%	80% UCR
Other Services *Refer to Summary Plan Description*	90%	80% UCR
Ambulance	80%	80% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carrover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availablility

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.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

80% Plan - Option I
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$200	$200
Family	$400	$400
Out-of-Pocket Maximum		
Employee	$600	$1,400
Family	$1,200	$2,800
Physician Office Visits and Telemedicine		
For Illness	80%	60% UCR
For Injury	100%	100% UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	60% UCR
Maternity Care	80%	60% UCR
Inpatient Hospital Services	80%	60% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services *(Labs, X-rays)*	80%	60% UCR
Outpatient Therapy Services	80%	60% UCR
Other Services *Refer to Summary Plan Description*	80%	60% UCR
Ambulance	80%	80% UCR
Annual Plan Maximum	UNLIMITED	UNLIMITED

Deductible and Out-of-Pocket Maximum are Integrated. Therefore, Deductible and Out-of-Pocket amounts met for Network Providers also apply to Deductible and Out-of-Pocket amounts met for Non-Network Providers.

Embedded Deductible. Each family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availablility

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.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

80% Plan - Option II
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$300	$300
Family	$600	$600
Out-of-Pocket Maximum		
Employee	$1,300	$2,300
Family	$2,600	$4,600
Physician Office Visits and Telemedicine		
For Illness	80%	60% UCR
For Injury	100%	100% UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	60% UCR
Maternity Care	80%	60% UCR
Inpatient Hospital Services	80%	60% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services *(Labs, X-rays)*	80%	60% UCR
Outpatient Therapy Services	80%	60% UCR
Other Services *Refer to Summary Plan Description*	80%	60% UCR
Ambulance	80%	80% UCR
Annual Plan Maximum	UNLIMITED	UNLIMITED

Deductible and Out-of-Pocket Maximum are Integrated. Therefore, Deductible and Out-of-Pocket amounts met for Network Providers also apply to Deductible and Out-of- Pocket amounts met for Non-Network Providers.

Embedded Deductible. Each family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availablility

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.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

80% Plan - Option III
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$500	$500
Family	$1,000	$1,000
Out-of-Pocket Maximum		
Employee	$1,500	$2,500
Family	$3,000	$5,000
Physician Office Visits and Telemedicine		
For Illness	80%	60% UCR
For Injury	100%	100% UCR
Prescription Drugs	80% *(after Network Deductible)*	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	60% UCR
Maternity Care	80%	60% UCR
Inpatient Hospital Services	80%	60% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services *(Labs, X-rays)*	80%	60% UCR
Outpatient Therapy Services	80%	60% UCR
Other Services *Refer to Summary Plan Description*	80%	60% UCR
Ambulance	80%	80% UCR
Annual Plan Maximum	UNLIMITED	UNLIMITED

Deductible and Out-of-Pocket Maximum are Integrated. Therefore, Deductible and Out-of-Pocket amounts met for Network Providers also apply to Deductible and Out-of-Pocket amounts met for Non-Network Providers.

Embedded Deductible. Each family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

$750/$1500 Plan
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$750	$1,500
Family	$1,500	$3,000
Out-of-Pocket Maximum		
Employee	$3,000	$6,000
Family	$6,000	$12,000
Physician Office Visits and Telemedicine		
For Illness	$25 Copayment	60% UCR
For Injury	100%	100% UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	60% UCR
Maternity Care	80%	60% UCR
Inpatient Hospital Services	80%	60% UCR
Emergency Services	$50 Copayment	100% UCR
Urgent Care	$25 Copayment	100% UCR
Diagnostic Services *(Labs, X-rays)*	80%	60% UCR
Outpatient Therapy Services	80%	60% UCR
Other Services *Refer to Summary Plan Description*	80%	60% UCR
Ambulance	80%	80% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availablility

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.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

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
Out-of-Pocket Maximum		
Employee	$600	$2,050
Family	$1,500	$6,150
Physician Office Visits and Telemedicine		
For Illness	$10 Copayment	65% UCR
For Injury	100%	100% UCR
OB/GYN	$5 Copayment	
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	65% UCR
Maternity Care	90%	65% UCR
Inpatient Hospital Services	90%	65% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services *(Labs, X-rays)*	90%	65% UCR
Outpatient Therapy Services	90%	65% UCR
Other Services *Refer to Summary Plan Description*	90%	65% UCR
Ambulance	80%	80% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availablility

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.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

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	$450
Family	$400	$900
Out-of-Pocket Maximum		
Employee	$700	$1,950
Family	$1,400	$3,900
Physician Office Visits and Telemedicine		
For Illness	$10 Copayment	70% UCR
For Injury	100%	100% UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	70% UCR
Maternity Care	90%	70% UCR
Inpatient Hospital Services	90%	70% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services *(Labs, X-rays)*	90%	70% UCR
Outpatient Therapy Services	90%	70% UCR
Other Services *Refer to Summary Plan Description*	90%	70% UCR
Ambulance	80%	80% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availablility

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.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

Aulternative 2000 E
HDHP - HSA Compatible
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,000	$4,000
Family	$4,000	$8,000
Out-of-Pocket Maximum		
Employee	$2,000	$8,000
Family	$4,000	$16,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$500	N/A
Family	$1,000	N/A
Physician Office Visits and Telemedicine		
For Illness	100%	80% UCR
For Injury	100%	100% UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services *(Labs, X-rays)*	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services *(Refer to Summary Plan Description)*	100%	80% UCR
Ambulance	100%	100% UCR
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.

Unembedded Deductible. Entire family deductible must be met before any plan payments are made for any individual family member.

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

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

Once the Medical Plan Deductible /Out-of-Pocket amount is met, there is an additional Pharmacy Out-of-Pocket amount which includes Pharmacy Copayments and Coinsurance. Once this Maximum is met, Prescription cost share will be waived.

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

Not all benefit descriptions and exclusions are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificate of Coverage which will govern.

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.

This Plan follows the Premium Managed Formulary

Prescription Copayments and Coinsurance apply after medical Deductible of $2,000 per covered person or $4,000 per family is met.

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment	$27 Copayment
Tier 1 *35-60 day supply*	$20 Copayment	
Tier 2	$30 Copayment	$72 Copayment
Tier 3	$60 Copayment or 50%, greater of	$145 Copayment
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	$27 Copayment	$27 Copayment
Tier 5	$72 Copayment	$72 Copayment
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 sixty (60) day supply may be obtained through the mail order program*		

No prescription Copayments after an additional Prescription Out-of-Pocket of $500 per covered person or $1,000 per family is met.

Tier Definitions

The medication tier may change due to new Drugs and Generic availablility

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.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

Aulternative 5000 D
HDHP - HSA Compatible
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$5,000	$7,500
Family	$10,000	$15,000
Out-of-Pocket Maximum		
Employee	$5,000	$10,000
Family	$10,000	$20,000
Physician Office Visits and Telemedicine		
For Illness	100%	80% UCR
For Injury	100%	100% UCR
Prescription Drugs *(Follow Premium Managed Formulary)*	100%	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services *(Labs, X-rays)*	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services *(Refer to Summary Plan Description)*	100%	80% UCR
Ambulance	100%	100% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

The Out-of-Pocket Maximum amount includes the Deductible and Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

Aulternative 1000/100 C
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,000	$2,000
Family	$2,000	$4,000
Out-of-Pocket Maximum		
Employee	$1,000	$4,000
Family	$2,000	$8,000
Physician Office Visits and Telemedicine		
For Illness	100%	80% UCR
For Injury	100%	100% UCR
Prescription Drugs *(Follow Premium Managed Formulary)*	100%	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services *(Labs, X-rays)*	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services *(Refer to Summary Plan Description)*	100%	80% UCR
Ambulance	100%	100% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

Not all benefit descriptions and exclusions are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificate of Coverage which will govern.

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.

Aulternative 1000/80 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,000	$2,000
Family	$2,000	$4,000
Out-of-Pocket Maximum		
Employee	$2,000	$4,000
Family	$4,000	$8,000
Physician Office Visits and Telemedicine		
For Illness	$25 Copayment	60% UCR
For Injury	$25 Copayment	$25 Copayment UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	80%	60% UCR
Inpatient Hospital Services	80%	60% UCR
Emergency Services	$50 Copayment	$50 Copayment UCR
Urgent Care	$25 Copayment	$25 Copayment UCR
Diagnostic Services *(Labs, X-rays)*	80%	60% UCR
Outpatient Therapy Services	80%	60% UCR
Other Services *Refer to Summary Plan Description*	80%	60% UCR
Ambulance	80%	80% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

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1-800-344-8858

This information is intended to provide a summary of products offered by AultCare.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availability

Tier 1 is defined as Preferred Generic medications.
Tier 2 is defined as Preferred Brand and Non-Preferred Generic medications.
Tier 3 is defined as Non-Preferred Brand and Non-Preferred Generic medications.
Tier 4 is defined as Specialty Generic medications.
Tier 5 is defined as Specialty Brand medications.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

Aulternative 1000/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,000	$2,000
Family	$2,000	$4,000
Out-of-Pocket Maximum		
Employee	$1,000	$4,000
Family	$2,000	$8,000
Physician Office Visits and Telemedicine		
For Illness	$25 Copayment	80% UCR
For Injury	$25 Copayment	$25 Copayment UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	$50 Copayment	$50 Copayment UCR
Urgent Care	$25 Copayment	$25 Copayment UCR
Diagnostic Services *(Labs, X-rays)*	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services *Refer to Summary Plan Description*	100%	80% UCR
Ambulance	100%	100% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

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This information is intended to provide a summary of products offered by AultCare.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availabiility

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.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

Aulternative 1500/90 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,500	$3,000
Family	$3,000	$6,000
Out-of-Pocket Maximum		
Employee	$2,500	$6,000
Family	$5,000	$12,000
Physician Office Visits and Telemedicine		
For Illness	$25 Copayment	70% UCR
For Injury	$25 Copayment	$25 Copayment UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	90%	70% UCR
Inpatient Hospital Services	90%	70% UCR
Emergency Services	$150 Copayment	$150 Copayment UCR
Urgent Care	$50 Copayment	$50 Copayment UCR
Diagnostic Services *(Labs, X-rays)*	90%	70% UCR
Outpatient Therapy Services	90%	70% UCR
Other Services *Refer to Summary Plan Description*	90%	70% UCR
Ambulance	90%	90% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

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1-800-344-8858

This information is intended to provide a summary of products offered by AultCare.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availablility

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.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

Aulternative 1500/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,500	$3,000
Family	$3,000	$6,000
Out-of-Pocket Maximum		
Employee	$1,500	$6,000
Family	$3,000	$12,000
Physician Office Visits and Telemedicine		
For Illness	$25 Copayment	80% UCR
For Injury	$25 Copayment	$25 Copayment UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	$150 Copayment	$150 Copayment UCR
Urgent Care	$50 Copayment	$50 Copayment UCR
Diagnostic Services *(Labs, X-rays)*	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services *Refer to Summary Plan Description*	100%	80% UCR
Ambulance	100%	100% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

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1-800-344-8858

This information is intended to provide a summary of products offered by AultCare.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availability

Tier 1 is defined as Preferred Generic medications.
Tier 2 is defined as Preferred Brand and Non-Preferred Generic medications.
Tier 3 is defined as Non-Preferred Brand and Non-Preferred Generic medications.
Tier 4 is defined as Specialty Generic medications.
Tier 5 is defined as Specialty Brand medications.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

Aulternative 2000/80 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,000	$4,000
Family	$4,000	$8,000
Out-of-Pocket Maximum		
Employee	$4,000	$8,000
Family	$8,000	$16,000
Physician Office Visits and Telemedicine		
For Illness	$25 Copayment	60% UCR
For Injury	$25 Copayment	$25 Copayment UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	80%	60% UCR
Inpatient Hospital Services	80%	60% UCR
Emergency Services	$50 Copayment	$50 Copayment UCR
Urgent Care	$25 Copayment	$25 Copayment UCR
Diagnostic Services *(Labs, X-rays)*	80%	60% UCR
Outpatient Therapy Services	80%	60% UCR
Other Services *Refer to Summary Plan Description*	80%	60% UCR
Ambulance	80%	80% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

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This information is intended to provide a summary of products offered by AultCare.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availability

Tier 1 is defined as Preferred Generic medications.
Tier 2 is defined as Preferred Brand and Non-Preferred Generic medications.
Tier 3 is defined as Non-Preferred Brand and Non-Preferred Generic medications.
Tier 4 is defined as Specialty Generic medications.
Tier 5 is defined as Specialty Brand medications.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

Aulternative 2000/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,000	$4,000
Family	$4,000	$8,000
Out-of-Pocket Maximum		
Employee	$2,000	$8,000
Family	$4,000	$16,000
Physician Office Visits and Telemedicine		
For Illness	$25 Copayment	80% UCR
For Injury	$25 Copayment	$25 Copayment UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	$50 Copayment	$50 Copayment UCR
Urgent Care	$25 Copayment	$25 Copayment UCR
Diagnostic Services *(Labs, X-rays)*	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services *Refer to Summary Plan Description*	100%	80% UCR
Ambulance	100%	100% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

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1-800-344-8858

This information is intended to provide a summary of products offered by AultCare.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

The medication tier may change due to new Drugs and Generic availability

Tier 1 is defined as Preferred Generic medications.
Tier 2 is defined as Preferred Brand and Non-Preferred Generic medications.
Tier 3 is defined as Non-Preferred Brand and Non-Preferred Generic medications.
Tier 4 is defined as Specialty Generic medications.
Tier 5 is defined as Specialty Brand medications.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for $0 Copayment. To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for $0 Copayment through your Pharmacy Benefit

- Contour Next Test Strips
- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

Aulternative 2500 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,500	$4,000
Family	$5,000	$8,000
Out-of-Pocket Maximum		
Employee	$2,500	$8,000
Family	$5,000	$16,000
Physician Office Visits and Telemedicine		
For Illness	$25 Copayment	80% UCR
For Injury	$25 Copayment	$25 Copayment UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	$50 Copayment	$50 Copayment UCR
Urgent Care	$25 Copayment	$25 Copayment UCR
Diagnostic Services *(Labs, X-rays)*	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services *Refer to Summary Plan Description*	100%	80% UCR
Ambulance	100%	100% UCR
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 family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

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.

This Plan follows the Premium Managed Formulary

Prescription Drugs	**Retail**	**Mail Order** (*60 day supply)*
Tier 1 *1-34 day supply*	$10 Copayment or 20%, greater of	$27 Copayment
Tier 1 *35-60 day supply*	$27 Copayment	
Tier 2	$20 Copayment or 30%, greater of	$55 Copayment
Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

Tier Definitions

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This information is intended to provide a summary of products offered by AultCare.

Aulternative 5000 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$5,000	$7,500
Family	$10,000	$15,000
Out-of-Pocket Maximum		
Employee	$5,000	$10,000
Family	$10,000	$20,000
Physician Office Visits and Telemedicine		
For Illness	$25 Copayment	80% UCR
For Injury	$25 Copayment	$25 Copayment UCR
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	$50 Copayment	$50 Copayment UCR
Urgent Care	$25 Copayment	$25 Copayment UCR
Diagnostic Services *(Labs, X-rays)*	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services *Refer to Summary Plan Description*	100%	80% UCR
Ambulance	100%	100% UCR
Annual Plan Maximum	UNLIMITED	UNLIMITED

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Embedded Deductible. Each family member only needs to meet his/her individual deductible prior to receiving any benefits.

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

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

The Out-of-Pocket Maximum amount includes the Deductible and Medical Coinsurance.

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

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Tier 3	$45 Copayment or 50%, greater of	$110 Copayment
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Tier 4	$125 Copayment or 20%, greater of	$125 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 sixty (60) day supply may be obtained through the mail order program*		

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Products covered for $0 Copayment through your Pharmacy Benefit

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- Contour Next Control Solution
- Microlet Next Lancing Device
- Microlet Lancets
- All generic Lancets

This information is intended to provide a summary of products offered by AultCare.

Aulternative 2000/100 A
HDHP - HSA Compatible
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,000	$4,000
Family	$4,000	$8,000
Out-of-Pocket Maximum		
Employee	$2,000	$8,000
Family	$4,000	$16,000
Physician Office Visits and Telemedicine		
For Illness	100%	80% UCR
For Injury	100%	100% UCR
Prescription Drugs *(Follow Premium Managed Formulary)*	100%	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	80% UCR
Diagnostic Services *(Labs, X-rays)*	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services *(Refer to Summary Plan Description)*	100%	80% UCR
Ambulance	100%	100% UCR
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.

Unembedded Deductible. Entire family deductible must be met before any plan payments are made for any individual family member.

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

The Out-of-Pocket Maximum amount includes the Deductible and Coinsurance.

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

Not all benefit descriptions and exclusions are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificate of Coverage which will govern.

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.

Aulternative 2500 A
HDHP - HSA Compatible
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,500	$4,000
Family	$5,000	$8,000
Out-of-Pocket Maximum		
Employee	$2,500	$8,000
Family	$5,000	$16,000
Physician Office Visits and Telemedicine		
For Illness	100%	80% UCR
For Injury	100%	100% UCR
Prescription Drugs *(Follow Premium Managed Formulary)*	100%	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% UCR
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services *(Labs, X-rays)*	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services *(Refer to Summary Plan Description)*	100%	80% UCR
Ambulance	100%	100% UCR
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.

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