CANTON REGIONAL CHAMBER HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
5000 F
Health Savings Account (HSA) Compatible
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$5,000	$15,000
Family	$10,000	$30,000
Medical Plan Out-of-Pocket Maximum		
Employee	$5,000	$22,050
Family	$10,000	$44,100
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$750	N/A
Family	$1,500	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services *Refer to Summary Plan Description*	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 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 is waived for Network Preventive Health Services.

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

Once the Medical Plan Deductible and 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 copayments will be waived.

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 continued in the AultCare Insurance Company Medical Plan document 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 $5,000 per Covered Person or $10,000 per Family is met.

Prescription Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment	$25 Copayment
Tier 1 - *35-60 day supply*	$20 Copayment	
Tier 2	$30 Copayment	$85 Copayment
Tier 3	$60 Copayment or 50%, greater of	$170 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	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

No Pescription Copayments after an additional Prescription Out-of-Pocket of $750 per Covered Person or $1,500 per Family is met.

<u>Tier Definitions</u>

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.

CANTON REGIONAL CHAMBER HEALTH FUND

Administered by AULTCARE

Canton Regional Chamber Health Fund
3200 D
Health Savings Account (HSA) Compatible
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$3,200	$9,600
Family	$6,400	$19,200
Out-of-Pocket Maximum		
Employee	$3,200	$17,350
Family	$6,400	$34,700
Physician Office Visits and Telemedicine		
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
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% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (*Refer to Summary Plan Description)*	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 **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 is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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330-363-6360
1-800-344-8858

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

CANTON REGIONAL CHAMBER HEALTH FUND

Administered by AULTCARE

Canton Regional Chamber Health Fund
5000 D
Health Savings Account (HSA) Compatible
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$5,000	$15,000
Family	$10,000	$30,000
Out-of-Pocket Maximum		
Employee	$5,000	$22,050
Family	$10,000	$44,100
Physician Office Visits and Telemedicine		
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
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% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (*Refer to Summary Plan Description)*	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 **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 is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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330-363-6360
1-800-344-8858

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

CANTON REGIONAL CHAMBER HEALTH FUND

Administered by AULTCARE

Canton Regional Chamber Health Fund
6650 D
Health Savings Account (HSA) Compatible
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$6,650	$19,950
Family	$13,300	$39,900
Out-of-Pocket Maximum		
Employee	$6,650	$22,050
Family	$13,300	$44,100
Physician Office Visits and Telemedicine		
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
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% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (*Refer to Summary Plan Description)*	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 **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 is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document 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.

CANTON REGIONAL CHAMBER HEALTH FUND

Administered by AULTCARE

Canton Regional Chamber Health Fund
Maximum Limit D Plan
Health Savings Account (HSA) Compatible
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$8,050	$24,150
Family	$16,100	$48,300
Out-of-Pocket Maximum		
Employee	$8,050	$28,350
Family	$16,100	$56,700
Physician Office Visits and Telemedicine		
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
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% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (*Refer to Summary Plan Description)*	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 **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 is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document 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.

CANTON REGIONAL Chamber
HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
500/80 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$500	$1,500
Family	$1,000	$3,000
Medical Plan Out-of-Pocket Maximum		
Employee	$4,500	$13,500
Family	$9,000	$27,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$4,950	N/A
Family	$9,900	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	60% RBP
Behavioral Health	$25 Copayment	60% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	80%	60% RBP
Outpatient Therapy Services	80%	60% RBP
Other Services *Refer to Summary Plan Description*	80%	60% RBP
Ambulance	80%	80% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED

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

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

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

Not all benefit descriptions and exclusions are included in this document. Complete benefit descriptions and exclusions are continued in the AultCare Insurance Company Medical Plan document 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 Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $4,950 per Covered Person or $9,900 per Family.
Once this Maximum is met, Prescription Copayments will be waived.

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.

CANTON REGIONAL Area CHAMBER
HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
1000/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,000	$3,000
Family	$2,000	$6,000
Medical Plan Out-of-Pocket Maximum		
Employee	$1,000	$6,000
Family	$2,000	$12,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$8,450	N/A
Family	$16,900	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Behavioral Health	$25 Copayment	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services *Refer to Summary Plan Description*	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 **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.

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

Not all benefit descriptions and exclusions are included in this document. Complete benefit descriptions and exclusions are continued in the AultCare Insurance Company Medical Plan document 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 Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $8,450 per Covered Person or $16,900 per Family.
Once this Maximum is met, Prescription Copayments will be waived.

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.

CANTON REGIONAL Area CHAMBER
HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
1500/80 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,500	$4,500
Family	$3,000	$9,000
Medical Plan Out-of-Pocket Maximum		
Employee	$2,500	$7,500
Family	$5,000	$15,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$6,950	N/A
Family	$13,900	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	60% RBP
Behavioral Health	$25 Copayment	60% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	80%	60% RBP
Outpatient Therapy Services	80%	60% RBP
Other Services *Refer to Summary Plan Description*	80%	60% RBP
Ambulance	80%	80% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED

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

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

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

Not all benefit descriptions and exclusions are included in this document. Complete benefit descriptions and exclusions are continued in the AultCare Insurance Company Medical Plan document which will govern.

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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** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $6,950 per Covered Person or $13,900 per Family.
Once this Maximum is met, Prescription Copayments will be waived.

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.

CANTON REGIONAL Area CHAMBER
HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
1500/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,500	$4,500
Family	$3,000	$9,000
Medical Plan Out-of-Pocket Maximum		
Employee	$1,500	$9,000
Family	$3,000	$18,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$7,950	N/A
Family	$15,900	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Behavioral Health	$25 Copayment	80% RBP
Prescription Drugs *See reverse side*		
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services *Refer to Summary Plan Description*	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 **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.

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

Not all benefit descriptions and exclusions are included in this document. Complete benefit descriptions and exclusions are continued in the AultCare Insurance Company Medical Plan document 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 Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $7,950 per Covered Person or $15,900 per Family.
Once this Maximum is met, Prescription Copayments will be waived.

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.

CANTON REGIONAL Area CHAMBER
HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
2000/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,000	$6,000
Family	$4,000	$12,000
Medical Plan Out-of-Pocket Maximum		
Employee	$2,000	$12,000
Family	$4,000	$24,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$7,450	N/A
Family	$14,900	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Behavioral Health	$25 Copayment	80% RBP
Prescription Drugs *See reverse side*		
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services *Refer to Summary Plan Description*	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 **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.

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

Not all benefit descriptions and exclusions are included in this document. Complete benefit descriptions and exclusions are continued in the AultCare Insurance Company Medical Plan document 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 Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $7,450 per Covered Person or $14,900 per Family.
Once this Maximum is met, Prescription Copayments will be waived.

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.

CANTON REGIONAL Chamber
HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
2500/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,500	$7,500
Family	$5,000	$15,000
Medical Plan Out-of-Pocket Maximum		
Employee	$2,500	$15,000
Family	$5,000	$30,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$6,950	N/A
Family	$13,900	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Behavioral Health	$25 Copayment	80% RBP
Prescription Drugs *See reverse side*		
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services *Refer to Summary Plan Description*	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 **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.

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

Not all benefit descriptions and exclusions are included in this document. Complete benefit descriptions and exclusions are continued in the AultCare Insurance Company Medical Plan document 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 Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $6,950 per Covered Person or $13,900 per Family.
Once this Maximum is met, Prescription Copayments will be waived.

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.

CANTON REGIONAL Area CHAMBER
HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
3000/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$3,000	$9,000
Family	$6,000	$18,000
Medical Plan Out-of-Pocket Maximum		
Employee	$3,000	$18,000
Family	$6,000	$36,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$6,450	N/A
Family	$12,900	N/A
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Behavioral Health	$25 Copayment	80% RBP
Prescription Drugs *See reverse side*		
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services *Refer to Summary Plan Description*	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 **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.

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

Pre-Approval is recommended for all Inpatient admissions.

Not all benefit descriptions and exclusions are included in this document. Complete benefit descriptions and exclusions are continued in the AultCare Insurance Company Medical Plan document 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 Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

There is an Out of Pocket Maximum of $6,450 per Covered Person or $12,900 per Family.
Once this Maximum is met, Prescription Copayments will be waived.

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.

CANTON REGIONAL Chamber
HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
5000/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$5,000	$15,000
Family	$10,000	$30,000
Medical Plan Out-of-Pocket Maximum		
Employee	$9,450	$28,350
Family	$18,900	$56,700
Prescription Drug Out-of-Pocket Maximum		
Employee	Integrated with Medical Network Out-of-Pocket	
Family		
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Behavioral Health	$25 Copayment	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services *Refer to Summary Plan Description*	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 **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.

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.

Deductible is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document 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 Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

<u>Tier Definitions</u>

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.

CANTON REGIONAL Chamber
HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
Maximum Limit B Plan
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$9,450	$24,300
Family	$18,900	$48,600
Medical Plan Out-of-Pocket Maximum		
Employee	$9,450	$28,350
Family	$18,900	$56,700
Prescription Drug Out-of-Pocket Maximum		
Employee	Integrated with Medical Network Out-of-Pocket	
Family		
Physician Office Visits and Telemedicine		
Illness/Injury	$25 Copayment	80% RBP
Behavioral Health	$25 Copayment	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services *Refer to Summary Plan Description*	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 **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.

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.

Deductible is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document 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 Drugs	**Retail**	**Mail Order** (*90 day supply)*
Tier 1 - *1-34 day supply*	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - *35-60 day supply*	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted Specialty Network pharmacy. Limited to a 30 day supply.		
Tier 4	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Tier 5	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of
A thirty four (34) day supply is available at the retail pharmacy *A sixty (60) day supply is available at the retail pharmacy for Tier 1* *A ninety (90) day supply may be obtained through the mail order program*		

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.

CANTON REGIONAL Chamber
HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
1600 A
Health Savings Account (HSA) Compatible
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,600	$4,800
Family	$3,200	$9,600
Out-of-Pocket Maximum		
Employee	$1,600	$9,600
Family	$3,200	$19,200
Physician Office Visits and Telemedicine		
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
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% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services *(Refer to Summary Plan Description)*	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 **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.

Deductible is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document 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.

CANTON REGIONAL CHAMBER HEALTH FUND
Administered by AULTCARE

Canton Regional Chamber Health Fund
2500 A
Health Savings Account (HSA) Compatible
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,500	$7,500
Family	$5,000	$15,000
Out-of-Pocket Maximum		
Employee	$2,500	$15,000
Family	$5,000	$30,000
Physician Office Visits and Telemedicine		
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
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% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services *(Labs, X-rays)*	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services *(Refer to Summary Plan Description)*	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 **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.

Deductible is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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