

Aulternative 1600/80 A HDHP - 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	\$4,025	\$12,075
Family	\$8,050	\$24,150
Physician Office Visits and Telemo	edicine	
Illness/Injury	80%	60% RBP
Behavioral Health	80%	60% RBP
Prescription Drugs (Follow Premium Managed Formulary)	80%	
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	100%	100% RBP
Urgent Care	80%	80% 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.

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.

7/2023



Aulternative 1600/100 A HDHP - HSA Compatible Schedule of Health Insurance Benefits

Network	Non-Network
\$1,600	\$4,800
\$3,200	\$9,600
\$1,600	\$9,600
\$3,200	\$19,200
edicine	
100%	80% RBP
100%	80% RBP
100%	
100%	500/ 555
100%	50% RBP
100%	80% RBP
100%	80% RBP
100%	100% RBP
100%	100% RBP
100%	80% RBP
100%	80% RBP
100%	80% RBP
100%	100% RBP
	\$1,600 \$3,200 \$1,600 \$3,200 edicine 100% 100% 100% 100% 100% 100% 100%

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Aulternative 2000/80 A HDHP - HSA Compatible Schedule of Health Insurance Benefits

ork	Non-Network	Network	Medical Benefits
			Calendar Year Deductible
	\$6,000	\$2,000	Employee
	\$12,000	\$4,000	Family
			Out-of-Pocket Maximum
	\$12,450	\$4,150	Employee
	\$19,950	\$6,650	Family
		ine	Physician Office Visits and Telemed
	60% RBP	80%	Illness/Injury
	60% RBP	80%	Behavioral Health
		80%	Prescription Drugs (Follow Premium Managed Formulary)
			Preventive Health Services
	50% RBP		As defined by
		1000/	the Affordable Care Act.
		100%	See www.healthcare.gov for
			additional information.
	60% RBP	80%	Maternity Care
,	60% RBP	80%	Inpatient Hospital Services
	80% RBP	80%	Emergency Services
	80% RBP	80%	Urgent Care
	60% RBP	80%	Diagnostic Services (Labs, X-rays)
,	60% RBP	80%	Outpatient Therapy Services
,	60% RBP	80%	Other Services (Refer to Summary Plan Description)
	80% RBP	80%	Ambulance
D	UNLIMITED	UNLIMITED	Annual Plan Maximum
	60% RBP 60% RBP 80% RBP	80% 80% 80%	Diagnostic Services (Labs, X-rays) Outpatient Therapy Services Other Services (Refer to Summary Plan Description) Ambulance

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

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$2,000	\$6,000
Family	\$4,000	\$12,000
Out-of-Pocket Maximum		
Employee	\$2,000	\$12,000
Family	\$4,000	\$24,000
Physician Office Visits and Telemo	edicine	
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	100%	50% RBP
additional information. Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services (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

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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.

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Aulternative 2500 A HDHP - 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 Telemedic	ine	
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	100%	50% RBP
additional information. Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services (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

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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.

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Aulternative 3000 A HDHP - HSA Compatible Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$3,000	\$9,000
Family	\$6,000	\$18,000
Out-of-Pocket Maximum		
Employee	\$3,000	\$18,000
Family	\$6,000	\$36,000
Physician Office Visits and Telemedic	cine	
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

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Aulternative 1000/80 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 Maxim	num	
Employee	\$2,000	\$6,000
Family	\$4,000	\$12,000
Prescription Drug Out-of-Pocket M	aximum Separate from	Medical
Employee	\$7,450	N/A
Family	\$14,900	N/A
Physician Office Visits and Tolomor	dicino	
Physician Office Visits and Telemed Illness/Injury	\$25 Copayment	60% RBP
Behavioral Health	\$25 Copayment	60% RBP
Benavioral Fredicti	323 copayment	0070 IVDI
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	1000/	E00/ DDD
See www.healthcare.gov for	100%	50% RBP
additional information.		
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
Sammary Fran Description;		
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.

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.

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.

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Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	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 red contracted Specialty Ne	quired. Medications must be twork pharmacy. Limited to a	_
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 reta	il pharmacy
A sixty (60) day supply	is available at the retail pharn	nacy for Tier 1
A ninety (90) day supply may be obtained through the mail order program		

There is a Prescription 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



Aulternative 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 Maxim	num	
Employee	\$1,000	\$6,000
Family	\$2,000	\$12,000
Prescription Drug Out-of-Pocket M	aximum Separate from	Medical
Employee	\$8,450	N/A
Family	\$16,900	N/A
		1.4
Physician Office Visits and Telemed		T
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	100%	50% RBP
additional information.		
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
	1000/	000/ DDD
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to	100%	000/ ppp
Summary Plan Description)	100%	80% RBP
Ambulance	100%	100% RBP
Annual Dian Mayirra		LINIUMATER
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.

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.

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Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
Tier 2	greater of	greater of (\$200 max)
Tion 2	\$45 Copayment or 50%,	\$130 Copayment or 45%,
Tier 3	greater of	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%,	\$10 Copayment or 20%,
1161 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
Her 5	greater of	greater of
A thirty four (34) day	supply is available at the reta	il pharmacy
A sixty (60) day supply is available at the retail pharmacy for Tier 1		nacy for Tier 1
A ninety (90) day supply may be obtained through the mail order program		

There is a Prescription 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.

is defined as Specialty Brand medications. Tier 5

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



Aulternative 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 Maxim	num	
Employee	\$2,500	\$7,500
Family	\$5,000	\$15,000
Duncavintion Dunc Out of Docket M	evimenta franc	Madical
Prescription Drug Out-of-Pocket M Employee	separate from \$6,950	N/A
Family	\$13,900	N/A
Turriny	\$13,900	IV/A
Physician Office Visits and Telemed	dicine	
Illness/Injury	\$25 Copayment	60% RBP
Behavioral Health	\$25 Copayment	60% RBP
Prescription Drugs	See Reverse side	
rescription brugs	See Neverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for	10070	3670 1121
additional information.		
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	200/	C00/ DDD
(Labs, X-rays)	80%	60% RBP
Outpatient Therapy Services	80%	60% RBP
Other Services (Refer to	900/	60% RBP
Summary Plan Description)	80%	UU/0 KDP
Ambulance	80%	80% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED
-		1

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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.

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1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
	greater of	greater of (\$200 max)
Tion 2	\$45 Copayment or 50%,	\$130 Copayment or 45%,
Tier 3	greater of	greater of (\$400 max)
Tier 4 and 5 - Prior Authorization i contracted Specialty	s required. Medications must be y Network pharmacy. Limited to a	

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 a Prescription 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.

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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



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Calendar Year Deductible		
Employee	\$1,500	\$4,500
Family	\$3,000	\$9,000
Medical Plan Out-of-Pocket Maxim	ıum	
Employee	\$1,500	\$9,000
Family	\$3,000	\$18,000
Prescription Drug Out-of-Pocket M	aximum Separate from	Medical
Employee	\$7,950	N/A
Family	\$15,900	N/A
Physician Office Visits and Telemed	dicino	
Illness/Injury	\$25 Copayment	80% RBP
Behavioral Health	\$25 Copayment	80% RBP
Della violai Tieatei	\$25 copayment	0070 KBI
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for	100%	30% KBP
additional information.		
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	1000/	200/ 222
(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
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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.

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Contact AultCare

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



\$10 Copayment or 20%, greater of \$20 Copayment or 20%, greater of	\$25 Copayment or 20%, greater of
\$20 Copayment or 20%,	greater of
greater of	
greater or	
\$30 Copayment or 30%,	\$85 Copayment or 25%,
greater of	greater of (\$200 max)
\$45 Copayment or 50%,	\$130 Copayment or 45%,
greater of	greater of (\$400 max)
	greater of \$45 Copayment or 50%,

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%,	\$10 Copayment or 20%,
Het 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
	greater of	greater of

A thirty four (34) day supply is available at the retail pharmacy
A sixty (60) day supply is available at the retail pharmacy for Tier 1
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



Aulternative 2000/80 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 Maxim	num	
Employee	\$4,000	\$12,000
Family	\$8,000	\$24,000
Prescription Drug Out-of-Pocket M	laximum Separate from	Medical
Employee	\$5,450	N/A
Family	\$10,900	N/A
Physician Office Visits and Telemed	dicino	
Illness/Injury	\$25 Copayment	60% RBP
Behavioral Health	\$25 Copayment	60% RBP
Benavioral Treater	723 copayment	0070 NB1
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for	100%	30% KBF
additional information.		
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	000/	C00/ 222
(Labs, X-rays)	80%	60% RBP
Outpatient Therapy Services	80%	60% RBP
Other Services (Refer to	80%	60% RBP
Summary Plan Description)		
Ambulance	80%	80% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED
		1

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.

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, 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



Retail	Mail Order (90 day supply)
\$10 Copayment or 20%,	\$25 Copayment or 20%,
greater of	greater of
\$20 Copayment or 20%,	
greater of	
\$30 Copayment or 30%,	\$85 Copayment or 25%,
greater of	greater of (\$200 max)
\$45 Copayment or 50%,	\$130 Copayment or 45%,
greater of	greater of (\$400 max)
	\$10 Copayment or 20%, greater of \$20 Copayment or 20%, greater of \$30 Copayment or 30%, greater of \$45 Copayment or 50%,

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%,	\$10 Copayment or 20%,
Her 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
	greater of	greater of

A thirty four (34) day supply is available at the retail pharmacy
A sixty (60) day supply is available at the retail pharmacy for Tier 1
A ninety (90) day supply may be obtained through the mail order program

There is an Out of Pocket Maximum of \$5,450 per Covered Person or \$10,900 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



Aulternative 2000/100 B Schedule of Health Insurance Benefits

Network	Non-Network
\$2,000	\$6,000
\$4,000	\$12,000
 mum	
\$2,000	\$12,000
\$4,000	\$24,000
Maximum Senarate from	Medical
	N/A
\$14,900	N/A
adicina	
	80% RBP
	80% RBP
723 copayment	0070 KBI
See Reverse side	
_	
100%	EOO/ DDD
100%	50% RBP
100%	80% RBP
100%	80% RBP
\$150 Copayment	\$150 Copayment RBP
\$50 Copayment	\$50 Copayment RBP
100%	80% RBP
10070	00% NDF
100%	80% RBP
100%	80% RBP
100%	100% RBP
1	\$2,000 \$4,000 mum \$2,000 \$4,000 Maximum Separate from \$7,450 \$14,900 edicine \$25 Copayment \$25 Copayment \$26 Copayment \$100% 100% 100% 100% 100% 100% 100% 100% 100%

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.

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, 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



\$10 Copayment or 20%, greater of \$20 Copayment or 20%, greater of	\$25 Copayment or 20%, greater of
\$20 Copayment or 20%,	greater of
greater of	
greater or	
\$30 Copayment or 30%,	\$85 Copayment or 25%,
greater of	greater of (\$200 max)
\$45 Copayment or 50%,	\$130 Copayment or 45%,
greater of	greater of (\$400 max)
	greater of \$45 Copayment or 50%,

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%,	\$10 Copayment or 20%,
Het 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
	greater of	greater of

A thirty four (34) day supply is available at the retail pharmacy
A sixty (60) day supply is available at the retail pharmacy for Tier 1
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



Aulternative 2500 B Schedule of Health Insurance Benefits

Network	Non-Network
\$2,500	\$7,500
\$5,000	\$15,000
mum	
	\$15,000
\$5,000	\$30,000
Maximum Senarate from	Medical
	N/A
\$13,900	N/A
odicino	
	80% RBP
	80% RBP
Ψ=0 σομαγσ	50/4 1.51
See Reverse side	
100%	50% RBP
100%	30% KBP
100%	80% RBP
100%	80% RBP
\$150 Copayment	\$150 Copayment RBP
\$50 Copayment	\$50 Copayment RBP
100%	80% RBP
100%	80% KBF
100%	80% RBP
100%	80% RBP
100%	100% RBP
ľ	\$2,500 \$5,000 mum \$2,500 \$5,000 Maximum Separate from \$6,950 \$13,900 edicine \$25 Copayment \$25 Copayment \$26 Reverse side 100% 100% \$150 Copayment \$50 Copayment

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

Embedded Deductible. Each 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.

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, exclusions and limitations are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificates of Coverage and Benefit Chart.

Contact AultCare

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



Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
rier z	greater of	greater of (\$200 max)
Tier 3	\$45 Copayment or 50%,	\$130 Copayment or 45%,
	greater of	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%,	\$10 Copayment or 20%,
Het 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
	greater of	greater of

A thirty four (34) day supply is available at the retail pharmacy A sixty (60) day supply is available at the retail pharmacy for Tier 1 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.
- is defined as Non-Preferred Brand and Non-Preferred Generic medications. Tier 3
- 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



Aulternative 5000 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 Maxi	mum	
Employee	\$9,450	\$28,350
Family	\$18,900	\$56,700
Prescription Drug Out-of-Pocket I		.tala NA - di - d
Employee		vith Medical
Family	Network Ot	ut-of-Pocket
Physician Office Visits and Telemo	edicine	
Illness/Injury	\$25 Copayment	80% RBP
Behavioral Health	\$25 Copayment	80% RBP
	Coo Doverno sido	
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for	100/0	
additional information.		
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
(2003, A 10y3)		
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to	10001	000/
Summary Plan Description)	100%	80% RBP
Ambulance	100%	100% RBP
Allibulatice	100/0	TOO/0 NDF
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.

Deductible is waived for Network Preventive Health Services.

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

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



Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
Her 2	greater of	greater of (\$200 max)
Tier 3	\$45 Copayment or 50%,	\$130 Copayment or 45%,
	greater of	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%,	\$10 Copayment or 20%,
Het 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
	greater of	greater of

A thirty four (34) day supply is available at the retail pharmacy
A sixty (60) day supply is available at the retail pharmacy for Tier 1
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



Aulternative 7150 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$7,150	\$21,450
Family	\$14,300	\$42,900
Medical Plan Out-of-Pocket Maxi	mum	
Employee	\$9,450	\$28,350
Family	\$18,900	\$56,700
Prescription Drug Out-of-Pocket I	Maximum	
Employee	Integrated with Medical	
Family	Network O	ut-of-Pocket
Physician Office Visits and Telemo	edicine	
Illness/Injury	\$25 Copayment	80% RBP
Behavioral Health	\$25 Copayment	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		<u></u>
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for		
additional information.		
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	40557	000/
(Labs, X-rays)	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to	100%	80% RBP
Summary Plan Description)	100/0	OU/0 NDF
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 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.

Deductible is waived for Network Preventive Health Services.

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

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



Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
	greater of	greater of (\$200 max)
Tier 3	\$45 Copayment or 50%,	\$130 Copayment or 45%,
	greater of	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%,	\$10 Copayment or 20%,
Het 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
	greater of	greater of

A thirty four (34) day supply is available at the retail pharmacy
A sixty (60) day supply is available at the retail pharmacy for Tier 1
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



Aulternative B Maximum Limit 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 Maxi	mum	
Employee	\$9,450	\$28,350
Family	\$18,900	\$56,700
Prescription Drug Out-of-Pocket I	Maximum	
Employee		with Medical
Family	Network O	ut-of-Pocket
Physician Office Visits and Telemo	edicine	
Illness/Injury	\$25 Copayment	80% RBP
Behavioral Health	\$25 Copayment	80% RBP
	0 0 11	
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for	100/0	30% ((2)
additional information.		
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	1000/	000/ 555
(Labs, X-rays)	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to	100%	80% RBP
Summary Plan Description)	100/0	3070 1101
Ambulance	100%	100% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED

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

Embedded Deductible. Each 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.

Deductible is waived for Network Preventive Health Services.

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

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



syment or 20%, \$25 Copayment or 20%, greater of greater of syment or 20%, reater of syment or 30%, \$85 Copayment or 25%,
eyment or 20%, reater of
reater of
ayment or 30%, \$85 Copayment or 25%,
reater of (\$200 max)
syment or 50%, \$130 Copayment or 45%,
reater of greater of (\$400 max)
6

Tier 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Het 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
	greater of	greater of

A thirty four (34) day supply is available at the retail pharmacy
A sixty (60) day supply is available at the retail pharmacy for Tier 1
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



Aulternative 3200 D HDHP - 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 Telemedic	ine	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs (Follow Premium Managed Formulary)	100%	100%
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for	100%	
additional information.		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services (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
<u> </u>		•

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 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



Aulternative 5000 D HDHP - 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 Telemed	dicine	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs (Follow Premium Managed Formulary)	100%	100%
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for	100%	50% RBP
additional information. Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services (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 <u>DO NOT</u> 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 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



Aulternative 6650 D HDHP - 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 Teleme	dicine	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs (Follow Premium Managed Formulary)	100%	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 <u>DO NOT</u> 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 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



Aulternative D Maximum Limit Plan HDHP - 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 Telemedic	cine	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs (Follow Premium Managed Formulary)	100%	100%
Preventive Health Services		
As defined by		
the Affordable Care Act.	1000/	50% RBP
See www.healthcare.gov for	100%	30% KBP
additional information.		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services (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.

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



Aulternative 1600 E HDHP - 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
Medical Plan Out-of-Pocket Maximu	ım	
Employee	\$1,600	\$9,600
Family	\$3,200	\$19,200
 Prescription Drug Out-of-Pocket Ma	ximum Separate from Mo	edical
Employee	\$750	N/A
Family	\$1,500	N/A
		-4
Physician Office Visits and Telemed		
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services	1	
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for		
additional information.		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
F	1000/	1000/ DDD
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Orgent care	100/0	100% NDF
Diagnostic Services	100%	80% RBP
		2070 1131
Outpatient Therapy Services	100%	80% RBP
		·
Other Services (Refer to Summary	4000/	000/ 222
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 <u>DO</u>
<u>NOT</u> 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 and Out-of-Pocket has been satisfied, there is an additional Pharmacy Out-of-Pocket Maximum..

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



Prescription Copayments apply after medical Deductible of \$1,600 per Covered Person or \$3,200 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 req	uired. Medications must be o	obtained through an AultCare
contracted Specialty Net	twork 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 retai	l pharmacy
A sixty (60) day supply	is available at the retail pharm	acy for Tier 1
A ninety (90) day supply m	ay be obtained through the mo	ail order program

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

Tier Definitions

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

Tier 1	is defined as	Preferred	Generic n	nedications.
1101 1	is actifica as	I I CICII CU	OCHER IC	iculculions.

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



Aulternative 2500 E HDHP - 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
Medical Plan Out-of-Pocket Maximu	<u> </u>	
Employee	\$2,500	\$15,000
Family	\$5,000	\$30,000
Prescription Drug Out-of-Pocket Ma	ximum Separate from Me	edical
Employee	\$750	N/A
Family	\$1,500	N/A
Physician Office Visits and Telemed	icina	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
25/6/15/4/17/54/17	200,0	0070 1121
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for	100%	30% NDF
additional information.		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
inputent nospital services	10070	0070 NB1
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services	100%	80% RBP
(Labs, X-rays)		
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to Summary	4200/	600/ 555
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 <u>DO</u>
<u>NOT</u> 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 and Out-of-Pocket has been satisfied, there is an additional Pharmacy Out-of-Pocket Maximum.

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



Prescription Copayments apply after medical Deductible of \$2,500 per Covered Person or \$5,000 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 re	equired. Medications must be o	obtained through an AultCare
contracted Specialty N	etwork 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) da	y supply is available at the retai	l pharmacy
A sixty (60) day supply	y is available at the retail pharm	acy for Tier 1
A ninety (90) day supply r	may be obtained through the mo	ail order program

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

Tier Definitions

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

Tier 1	is defined a	Proformad	Generic	medications.
HELT.	is ucilieu a:	S FICICIICU	Generic	illeulcations.

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



Aulternative 3200 F HDHP - 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
Medical Plan Out-of-Pocket Maxii	<u> </u> num	
Employee	\$3,200	\$19,200
Family	\$6,400	\$38,400
Prescription Drug Out-of-Pocket N	<u> </u> Maximum Separate from M	<u> </u> edical
Employee	\$750	N/A
Family	\$1,500	N/A
Physician Office Visits and Teleme	<u> </u> edicine	
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	100%	50% RBP
additional information.		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
	20070	0076 1121
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
orgent care	10070	10070 1101
Diagnostic Services	100%	80% RBP
(Labs, X-rays)	10070	00% KBI
Outpatient Therapy Services	100%	80% RBP
••	1	
Other Services (Refer to	100%	80% RBP
Summary Plan Description)	100%	OU% NDP
Ambulance	100%	100% RBP
	1	
Annual Plan Maximum	UNLIMITED	UNLIMITED

Deductible and Out-of-Pocket Maximum are Non-Integrated. Therefore,

Deductible and Out-of-Pocket amounts met for Network Providers <u>DO NOT</u> apply to Deductible and Out-of-Pocket amounts met for Non-Network Providers.

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

Once the Medical Plan Deductible and Out-of-Pocket has been satisfied there is an additional Pharmacy Out-of-Pocket Maximum.

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



Prescription Copayments apply after medical Deductible of \$3,200 per Covered Person or \$6,400 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 o	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 retai	il pharmacy
A sixty (60) day sup	oply is available at the retail pharm	acy for Tier 1
A ninety (90) day supp	ly may be obtained through the mo	ail order program

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

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



Aulternative 5000 F HDHP - 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 Maxin	num	
Employee	\$5,000	\$22,050
Family	\$10,000	\$44,100
Prescription Drug Out-of-Pocket N		
Employee	\$750	N/A
Family	\$1,500	N/A
 Physician Office Visits and Teleme	dicine	
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.	4000/	500/ 555
See www.healthcare.gov for	100%	50% RBP
additional information.		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services		
(Labs, X-rays)	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
- aspacione includy scretces	100/0	0070 IIDI
Other Services (Refer to	100%	80% RBP
Summary Plan Description)	100/0	OU/0 NDF
Ambulance	100%	100% RBP
	200/0	200,0 1101
Annual Plan Maximum	UNLIMITED	UNLIMITED

Deductible and Out-of-Pocket Maximum are Non-Integrated. Therefore, Deductible and Out-of-Pocket amounts

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

Once the Medical Plan Deductible and Out-of-Pocket has been satisfied there is an additional Pharmacy Out-of-Pocket Maximum.

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



Prescription Copayments apply after medical Deductible of \$5,000 per Covered Person or \$10,000 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 retai	il pharmacy
A sixty (60) day sup	ply is available at the retail pharm	acy for Tier 1
A ninety (90) day suppl	y may be obtained through the mo	ail order program

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

Tier Definitions

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

Tier 1	is defined as Preferred Generic medications
Her I	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



90% High Option Plan Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$150	\$450
Family	\$300	\$900
Medical Plan Out-of-Pocket Maxi	mum	
Employee	\$500	\$1,500
Family	\$1,000	\$3,000
Prescription Drug Out-of-Pocket	Maximum Separate from	Medical
Employee	\$8,950	N/A
Family	\$17,900	N/A
Physician Office Visits and Telem	edicine	
Illness/Injury	90%	80% RBP
Behavioral Health	90%	80% RBP
	Can Daviana aida	
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	80% RBP
See www.healthcare.gov for		3070 1121
additional information.		
Maternity Care	90%	80% RBP
Inpatient Hospital Services	90%	80% RBP
Emergency Services	\$75 Copayment	\$75 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services	90%	80% RBP
(Labs, X-rays)	3070	0070 KBI
Outpatient Therapy Services	90%	80% RBP
Other Services (Refer to Summary Plan Description)	90%	80% 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 <u>DO NOT</u> 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.

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, 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



Retail Mail Order (90 day supply	n Drugs
r 1 - \$10 Copayment or 20%, \$25 Copayment or 20%,	Tier 1 -
y supply greater of greater of	1-34 day supply
r 1 - \$20 Copayment or 20%,	Tier 1 -
gy supply greater of	35-60 day supply
\$30 Copayment or 30%, \$85 Copayment or 25%,	Tier 2
greater of greater of (\$200 max)	1161 2
\$45 Copayment or 50%, \$130 Copayment or 45%,	Tier 3
greater of greater of (\$400 max)	Her 3
greater of	

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%,	\$10 Copayment or 20%,
1161 4	greater of	greater of
Tion F	\$125 Copayment or 20%,	\$125 Copayment or 20%,
Tier 5	greater of	greater of

A thirty four (34) day supply is available at the retail pharmacy
A sixty (60) day supply is available at the retail pharmacy for Tier 1
A ninety (90) day supply may be obtained through the mail order program

There is an Out of Pocket Maximum of \$8,950 per Covered Person or \$17,900 per Family.

Once the Out of Pocket 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



80% Option II **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$300	\$900
Family	\$600	\$1,800
Medical Plan Out-of-Pocket Maxir	mum	
Employee	\$1,300	\$3,900
Family	\$2,600	\$7,800
Prescription Drug Out-of-Pocket N	Maximum Separate from	Medical
Employee	\$8,150	N/A
Family	\$16,300	N/A
Physician Office Visits and Teleme	edicine	
Illness/Injury	80%	60% RBP
Behavioral Health	80%	60% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	60% RBP
See www.healthcare.gov for		3070 1121
additional information.		
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	\$75 Copayment	\$75 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services	80%	60% RBP
(Labs, X-rays)		00/0 NB1
Outpatient Therapy Services	80%	60% RBP
Other Services (Refer to	80%	60% RBP
Jummury Fluit Description)		
Ambulance	80%	80% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED
Outpatient Therapy Services Other Services (Refer to Summary Plan Description) Ambulance	80% 80%	60% RBP 60% RBP

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.

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, 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



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greater of	greater of (\$400 max)
Modications must be	
pharmacy. Limited to	e obtained through an AultCare o a 30 day supply.
O Copayment or 20%,	\$10 Copayment or 20%,
greater of	greater of
5 Copayment or 20%,	\$125 Copayment or 20%,
	greater of
	• •

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 \$8,150 per Covered Person or \$16,300 per Family. Once the Out of Pocket 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



\$750/\$1500 Plan Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$750	\$2,250
Family	\$1,500	\$4,500
Medical Plan Out-of-Pocket Maxir	num	
Employee	\$3,000	\$9,000
Family	\$6,000	\$18,000
Prescription Drug Out-of-Pocket N	Maximum Separate from	Medical
Employee	\$6,450	N/A
Family	\$12,900	N/A
Physician Office Visits and Teleme	dicine	
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.	100%	60% RBP
See www.healthcare.gov for		00/0 KBF
additional information.		
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	\$75 Copayment	\$75 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services	80%	60% RBP
(Labs, X-rays)		0070 KBI
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
Allitudi Pidii ividXiMuM	UNLIIVIIIEU	UNLIMITED

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

Embedded Deductible. Each 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.

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, exclusions and limitations are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificates of Coverage and Benefit Chart.

Contact AultCare

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



Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
T' 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
Tier 2	greater of	greater of (\$200 max)
Tion 2	\$45 Copayment or 50%,	\$130 Copayment or 45%,
Tier 3	greater of	greater of (\$400 max)
Tier 4 and 5 - Prior Authorization is contracted Specialty	required. Medications must be Network pharmacy. Limited to	
Tier 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Her 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
Her 5	greater of	greater of
A thirty four (34)	day supply is available at the reta	il pharmacy

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

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

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



Group Purchasing Plan I Schedule of Health Insurance Benefits

Non Notwork

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$100	\$300
Family	\$300	\$900
Madical Dlan Out of Dealest Marrin		
Medical Plan Out-of-Pocket Maxin	\$600	¢1 900
Employee	\$1,500	\$1,800 \$4,500
Family	\$1,500	\$4,500
Prescription Drug Out-of-Pocket N	laximum Separate from	Medical
Employee	\$8,850	N/A
Family	\$17,400	N/A
Physician Office Visits and Teleme	dicine	
Illness/Injury	\$10 Copayment	65% RBP
OB/GYN	\$5 Copayment	65% RBP
Behavioral Health	\$10 Copayment	65% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		<u> </u>
As defined by the Affordable Care Act.	100%	65% RBP
See www.healthcare.gov for		
additional information.		
additional injormation.		
Maternity Care	90%	65% RBP
Inpatient Hospital Services	90%	65% RBP
· · · · · · · · · · · · · · · · · · ·	1	· · · · · · · · · · · · · · · · · · ·
Emergency Services	\$75 Copayment	\$75 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services	0.051	051/
(Labs, X-rays)	90%	65% RBP
Outpatient Therapy Services	90%	65% RBP
Other Services (Refer to	-	<u> </u>
Summary Plan Description)	90%	65% RBP
Ambulance	80%	80% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED

Notwork

Medical Renefits

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.

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, exclusions and limitations are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificates of Coverage and Benefit Chart.

Contact AultCare www.aultcare.com

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



Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
	greater of	greater of (\$200 max)
Tion 2	\$45 Copayment or 50%,	\$130 Copayment or 45%,
Tier 3	greater of	greater of (\$400 max)
Tier 4 and 5 - Prior Authorization is contracted Specialty	s required. Medications must be y Network pharmacy. Limited to a	•
Tion 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Tier 4	greater of	greater of
Tion F	\$125 Copayment or 20%,	\$125 Copayment or 20%,
Tier 5	greater of	greater of
A thirty four (34)	day supply is available at the reta	il pharmacy
4 -inter (CO) -lance	oply is available at the retail pharn	agou for Tior 1

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

There is an Out of Pocket Maximum of \$8,850 per Covered Person or \$17,400 per Family.

Once the Out of Pocket 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



Group Purchasing Plan III Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$200	\$600
Family	\$400	\$1,200
Medical Plan Out-of-Pocket Maxi	imum	
Employee	\$700	\$2,100
Family	\$1,400	\$4,200
Prescription Drug Out-of-Pocket	Maximum Separate from	Medical
Employee	\$8,750	N/A
Family	\$17,500	N/A
Physician Office Visits and Telem		
Illness/Injury	\$10 Copayment	70% RBP
Behavioral Health	\$10 Copayment	70% RBP
Benavioral ricardi	310 copayment	7070 1101
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		70% RBP
the Affordable Care Act.	100%	
See www.healthcare.gov for		
additional information.		
Maternity Care	90%	70% RBP
Inpatient Hospital Services	90%	70% RBP
Emergency Services	\$75 Copayment	\$75 Copayment RBP
		1
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services	90%	70º/ ppp
(Labs, X-rays)	3 0%	70% RBP
Outpatient Therapy Services	90%	70% RBP
Other Services (Refer to		
Summary Plan Description)	90%	70% RBP
Ambulance	80%	80% RRP
Ambulance Annual Plan Maximum	80%	80% RBP

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

Embedded Deductible. Each 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.

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, exclusions and limitations are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificates of Coverage and Benefit Chart.

Contact AultCare

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



Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
	greater of	greater of (\$200 max)
Tier 3	\$45 Copayment or 50%,	\$130 Copayment or 45%,
	greater of	greater of (\$400 max)
Tier 4 and 5 - Prior Authorization is contracted Specialty	required. Medications must be on Network pharmacy. Limited to a	
Tion 4		
Tior 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Tier 4	\$10 Copayment or 20%, greater of	\$10 Copayment or 20%, greater of
	' '	• • •
Tier 4 Tier 5	greater of	greater of
Tier 5	greater of \$125 Copayment or 20%,	greater of \$125 Copayment or 20%, greater of

There is an Out of Pocket Maximum of \$8,750 per Covered Person or \$17,500 per Family.

Once the Out of Pocket Maximum is met, Prescription Copayments will be waived.

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.
Her I	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