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 Telemedicine		
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.

Aulternative 1600/100 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	$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.

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.

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

Aulternative 2000/80 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	$4,150	$12,450
Family	$6,650	$19,950
Physician Office Visits and Telemedicine		
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	80%	80% 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.

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

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

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,000	$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 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.

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

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

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

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

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

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

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,500	$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.

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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.

Pre-Approval is recommended for all Inpatient admissions.

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1-800-344-8858

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

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 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 payents 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.

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

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

Aulternative 1000/80 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,000	$3,000
Family	$2,000	$6,000
Medical Plan Out-of-Pocket Maximum		
Employee	$2,000	$6,000
Family	$4,000	$12,000
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	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.

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

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 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

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

Aulternative 1000/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,000	$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.

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

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 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.
Tier 5 is defined as Specialty Brand medications.

Diabetic Program

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

Products covered for $0 Copayment through your Pharmacy Benefit

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

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

Aulternative 1500/80 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 dedutible 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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330-363-6360
1-800-344-8858

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

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 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.

Diabetic Program

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

Products covered for $0 Copayment through your Pharmacy Benefit

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

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

Aulternative 1500/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$1,500	$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.

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

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.

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 Maximum		
Employee	$4,000	$12,000
Family	$8,000	$24,000
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$5,450	N/A
Family	$10,900	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.

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

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

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 $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

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

Aulternative 2000/100 B
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,000	$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.

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

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

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.

Aulternative 2500 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.

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

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

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.

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 Maximum		
Employee	$9,450	$28,350
Family	$18,900	$56,700
Prescription Drug Out-of-Pocket Maximum		
Employee	Integrated with Medical	
Family	Network Out-of-Pocket	
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.

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

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

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.

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 Maximum		
Employee	$9,450	$28,350
Family	$18,900	$56,700
Prescription Drug Out-of-Pocket Maximum		
Employee	Integrated with Medical	
Family	Network Out-of-Pocket	
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.

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

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

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.

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 Maximum		
Employee	$9,450	$28,350
Family	$18,900	$56,700
Prescription Drug Out-of-Pocket Maximum		
Employee	Integrated with Medical	
Family	Network Out-of-Pocket	
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.

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

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

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.

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 Telemedicine		
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 **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

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

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

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$5,000	$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%	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.

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

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

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

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

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

Aulternative 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 Telemedicine		
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 **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

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

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 Telemedicine		
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 **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

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

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 Maximum		
Employee	$1,600	$9,600
Family	$3,200	$19,200
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	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.

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

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

This Plan follows the Premium Managed Formulary

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

Diabetic Program

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

Products covered for $0 Copayment through your Pharmacy Benefit

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

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

Aulternative 2500 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 Maximum		
Employee	$2,500	$15,000
Family	$5,000	$30,000
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.

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

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

7/2023

This Plan follows the Premium Managed Formulary

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 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 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 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.

7/2023

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 Maximum		
Employee	$3,200	$19,200
Family	$6,400	$38,400
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.

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

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

AULTCARE

This Plan follows the Premium Managed Formulary

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 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 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

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

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 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.

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

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

7/2023

AULTCARE

This Plan follows the Premium Managed Formulary

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 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 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

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

7/2023

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 Maximum		
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 Telemedicine		
Illness/Injury	90%	80% RBP
Behavioral Health	90%	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%	80% RBP
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 *(Labs, X-rays)*	90%	80% RBP
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 **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

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

7/2023

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 $8,950 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

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

7/2023

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 Maximum		
Employee	$1,300	$3,900
Family	$2,600	$7,800
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$8,150	N/A
Family	$16,300	N/A
Physician Office Visits and Telemedicine		
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. See www.healthcare.gov for additional information.	100%	60% RBP
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 *(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.

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

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

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 $8,150 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

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

$750/$1500 Plan
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$750	$2,250
Family	$1,500	$4,500
Medical Plan Out-of-Pocket Maximum		
Employee	$3,000	$9,000
Family	$6,000	$18,000
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	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%	60% RBP
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 *(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.

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

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

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 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

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

Group Purchasing Plan I
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$100	$300
Family	$300	$900
Medical Plan Out-of-Pocket Maximum		
Employee	$600	$1,800
Family	$1,500	$4,500
Prescription Drug Out-of-Pocket Maximum *Separate from Medical*		
Employee	$8,850	N/A
Family	$17,400	N/A
Physician Office Visits and Telemedicine		
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		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	65% RBP
Maternity Care	90%	65% RBP
Inpatient Hospital Services	90%	65% RBP
Emergency Services	$75 Copayment	$75 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	90%	65% RBP
Outpatient Therapy Services	90%	65% RBP
Other Services *(Refer to Summary Plan Description)*	90%	65% 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.

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

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

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 $8,850 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

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

Group Purchasing Plan III
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$200	$600
Family	$400	$1,200
Medical Plan Out-of-Pocket Maximum		
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 Telemedicine		
Illness/Injury	$10 Copayment	70% RBP
Behavioral Health	$10 Copayment	70% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	70% RBP
Maternity Care	90%	70% RBP
Inpatient Hospital Services	90%	70% RBP
Emergency Services	$75 Copayment	$75 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	90%	70% RBP
Outpatient Therapy Services	90%	70% RBP
Other Services *(Refer to Summary Plan Description)*	90%	70% 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.

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.

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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

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 $8,750 per Covered Person or $17,500 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

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

7/2023