

# **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network	Deductible and Out
Calendar Year Deductible			Maximum are Non- Therefore, Deductib
Employee	\$1,000	\$3,000	Pocket amounts me
Family	\$2,000	\$6,000	Providers <b>DO NOT</b> a  Deductible and Out-
			amounts met for No
Out-of-Pocket Maximum			Providers.
Employee	\$5,900	\$28,350	Embedded Deducti
Family	\$11,800	\$56,700	member only needs
			individual deductibl
Physician Office Visits			receiving any benef
Illness/Injury	\$25 Copayment	50% RBP	Appropriate Deduc
Telemedicine	\$25 Copayment	50% RBP	satisfied before any
Specialist Office Visits			except as noted.
Illness/Injury	\$45 Copayment	50% RBP	The Out-of-Pocket N
iliness/injury	у <del>4</del> 5 сораушенс	30% KBF	amount includes the
Prescription Drugs	See Reverse side		Copayments and Co
			 Deductible is waive
Preventive Health Services			Preventive Health S
As defined by			
the Affordable Care Act.	1000/	E00/ DDD	Pediatric Dental and
See www.healthcare.gov for	100%	50% RBP	age 19) are included Refer to certificate
additional information.			details.
	700/	F00/ DDD	Note: If you have pu
Maternity Care	70%	50% RBP	certified stand alon
Inpatient Hospital Services	70%	50% RBP	provided an attesta
inpatient nospital services	7070	30% KBF	regarding that plan,
Emergency Services	70%	70% RBP	pediatric dental, inc check-up, will be pr
zmergency services	7070	70701101	that dental plan.
Urgent Care	\$75 Copayment	\$75 Copayment RBP	Not all benefit descri
			exclusions and limit
Diagnostic Services	70%	50% RBP	included in this doc
(Labs, X-rays)			benefit descriptions are contained in the
Outrotion Thomas Commission	700/	F00/ DDD	Insurance Company
Outpatient Therapy Services	70%	50% RBP	Coverage and Benef
Other Services (Refer to	700/	500/ DDD	Contact AultCare
Summary Plan Description)	70%	50% RBP	www.aultcare.com
			330-363-6360 
Ambulance	70%	70% RBP	1 000 344-0030
Annual Plan Maximum	UNLIMITED	UNLIMITED	
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riptions, ations are ument. Complete and exclusions AultCare Certificates of it Chart.



Prescription Drugs	Retail (34 Day Supply Unless Noted)	Mail Order (90 day supply)
Tier 1 - 1-60 day supply/Retail	\$0 Copayment	\$0 Copayment
Tier 2 - 1-34 day supply	\$10 Copayment or 20%, greater of	\$30 Copayment or 20%, greater of
Tier 2 - 1-60 day supply/Retail	\$30 Copayment or 20%, greater of	
Tier 3	\$20 Copayment or 30%, greater of	\$55 Copayment or 25%, greater of
Tier 4	\$45 Copayment or 40%, greater of	\$125 Copayment or 35%, greater of
Tier 5 and 6 - Prior Authorization is requi Specialty Netw	red. Medications must be obtairork pharmacy. Limited to a 30 c	_
Tier 5	\$10 Copayment or 20%, greater of	N/A
Tier 6	\$50 Copayment or 50%, greater of	N/A

#### **Tier Definitions**

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

Tier 1	ic defined as	Preventive Maintenance	modications
Heri	is detined as	Preventive iviaintenance	medications

**Tier 2** is defined as Preferred Generic medications.

**Tier 3** is defined as Non-Preferred Generic and Preferred Brand medications.

**Tier 4** is defined as Non-Preferred Generic & Non-Preferred Brand medications.

**Tier 5** is defined as Preferred Generic Specialty medications.

**Tier 6** is defined as Preferred Brand Specialty 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



# **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network	Deductible and Out-of-I
			Maximum are Non-Inte
Calendar Year Deductible	¢4.200	¢2.500	Pocket amounts met for
Employee	\$1,200	\$3,600	Providers <b>DO NOT</b> apply
Family	\$2,400	\$7,200	Deductible and Out-of-P amounts met for Non-N
Out-of-Pocket Maximum			Providers.
Employee	\$7,000	\$28,350	Embedded Deductible.
Family	\$14,000	\$56,700	member only needs to r
			individual deductible pri
Physician Office Visits			receiving any benefits.
Illness/Injury	\$20 Copayment	60% RBP	Appropriate Deductible
Telemedicine	\$20 Copayment	60% RBP	satisfied before any ber
Specialist Office Visits			except as noted.
Specialist Office Visits  Illness/Injury	\$40 Copayment	60% RBP	The Out-of-Pocket Maxi
micssy mjury	учо сориутсте	0070 NDI	amount includes the Dec
Prescription Drugs	See Reverse side		Copayments and Coinsu
			Deductible is waived for
Preventive Health Services			Preventive Health Servi
As defined by			Pediatric Dental and Visi
the Affordable Care Act.	100%	60% RBP	age 19) are included in t
See www.healthcare.gov for			Refer to certificate for fu
additional information.			details.
Maternity Care	80%	60% RBP	Note: If you have purcha
waterinty care	8070	0070 NDF	<b>certified</b> stand alone del
Inpatient Hospital Services	80%	60% RBP	regarding that plan, cove
			pediatric dental, includir
Emergency Services	80%	80% RBP	check-up, will be provide that dental plan.
			that defital plan.
Urgent Care	\$75 Copayment	\$75 Copayment RBP	Not all benefit description
Diagnostic Comices			exclusions and limitation included in this document
Diagnostic Services	80%	60% RBP	benefit descriptions and
(Labs, X-rays)			are contained in the Aul
Outpatient Therapy Services	80%	60% RBP	Insurance Company Cert Coverage and Benefit Ch
,			
Other Services (Refer to	900/	COO/ DDD	Contact AultCare
Summary Plan Description)	80%	60% RBP	www.aultcare.com 330-363-6360
			1-800-344-8858
Ambulance	80%	80% RBP	
Annual Dian Maximum	LINILINAITED	LINILINAITED	
Annual Plan Maximum	UNLIMITED	UNLIMITED	

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Prescription Drugs	Retail (34 Day Supply Unless Noted)	Mail Order (90 day supply)
Tier 1 - 1-60 day supply/Retail	\$0 Copayment	\$0 Copayment
Tier 2 - 1-34 day supply	\$10 Copayment or 20%, greater of	\$30 Copayment or 20%, greater of
Tier 2 - 1-60 day supply/Retail	\$30 Copayment or 20%, greater of	
Tier 3	\$20 Copayment or 30%, greater of	\$55 Copayment or 25%, greater of
Tier 4	\$45 Copayment or 40%, greater of	\$125 Copayment or 35%, greater of
Tier 5 and 6 - Prior Authorization is require Specialty Netwo	ed. Medications must be obtai rk pharmacy. Limited to a 30 d	•
Tier 5	\$10 Copayment or 20%, greater of	N/A
Tier 6	\$50 Copayment or 50%, greater of	N/A

#### **Tier Definitions**

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

Tier 1	is defined	as Preventive Maintenance medications.	

**Tier 2** is defined as Preferred Generic medications.

**Tier 3** is defined as Non-Preferred Generic and Preferred Brand medications.

**Tier 4** is defined as Non-Preferred Generic & Non-Preferred Brand medications.

**Tier 5** is defined as Preferred Generic Specialty medications.

**Tier 6** is defined as Preferred Brand Specialty 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



# **Gold 1800**

## **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network	Deductible and Out- Maximum are Non-
			Therefore, Deductib
Calendar Year Deductible			Pocket amounts met
Employee	\$1,800	\$5,400	Providers <b>DO NOT</b> a
Family	\$3,600	\$10,800	Deductible and Out-
<u> </u>			amounts met for No  Providers.
Out-of-Pocket Maximum	4=	400.000	_
Employee	\$7,100	\$28,350	Embedded Deductik
Family	\$14,200	\$56,700	member only needs
			individual deductible
Physician Office Visits			receiving any benefit
Illness/Injury	\$20 Copayment	70% RBP	Appropriate Deduct
Telemedicine	\$20 Copayment	70% RBP	satisfied before any
			except as noted.
Specialist Office Visits			The Out-of-Pocket M
Illness/Injury	\$40 Copayment	70% RBP	amount includes the
			Copayments and Coi
Prescription Drugs	See Reverse side		
			Deductible is waived
Preventive Health Services			Preventive Health S
As defined by			Pediatric Dental and
the Affordable Care Act.	100%	70% RBP	age 19) are included
See www.healthcare.gov for	100%	70% KBF	Refer to certificate for
additional information.			details.
	000/	700/ DDD	Note: If you have pu
Maternity Care	90%	70% RBP	certified stand alone
	000/	700/ 888	provided an attestat
Inpatient Hospital Services	90%	70% RBP	regarding that plan, pediatric dental, incl
			check-up, will be pro
Emergency Services	90%	90% RBP	that dental plan.
Urgent Care	\$75 Copayment	\$75 Copayment RBP	Not all benefit descr
orgent care	375 copayment	ул сориутене кы	exclusions and limita
Diagnostic Services			included in this docu
(Labs, X-rays)	90%	70% RBP	benefit descriptions
(Lubs, X ruys)			are contained in the
Outpatient Therapy Services	90%	70% RBP	Insurance Company Coverage and Benefi
outputient merupy services	3070	7 0 70 1121	
Other Services (Refer to			Contact AultCare
Summary Plan Description)	90%	70% RBP	www.aultcare.com
			330-363-6360 1-800-344-8858
Ambulance	90%	90% RBP	1 000 344 0000
			_ _
Annual Plan Maximum	UNLIMITED	UNLIMITED	

**Deductible and Out-of-Pocket** -Integrated.

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Maximum e Deductible, oinsurance.

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d Vision (up to d in this plan. for full benefit

urchased a ne dental plan and ation to AultCare coverage for cluding a dental rovided through

criptions, tations are cument. Complete s and exclusions e AultCare Certificates of fit Chart.



Prescription Drugs	Retail (34 Day Supply Unless Noted)	Mail Order (90 day supply)
Tier 1 - 1-60 day supply/Retail	\$0 Copayment	\$0 Copayment
Tier 2 - 1-34 day supply	\$10 Copayment or 20%, greater of	\$30 Copayment or 20%, greater of
Tier 2 - 1-60 day supply/Retail	\$30 Copayment or 20%, greater of	
Tier 3	\$20 Copayment or 30%, greater of	\$55 Copayment or 25%, greater of
Tier 4	\$45 Copayment or 40%, greater of	\$125 Copayment or 35%, greater of
ier 5 and 6 - Prior Authorization is requi Specialty Netw	ired. Medications must be obtai ork pharmacy. Limited to a 30 d	
Tier 5	\$10 Copayment or 20%, greater of	N/A
Tier 6	\$50 Copayment or 50%, greater of	N/A

#### **Tier Definitions**

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

Tier 1	is defined	as Preventive	Maintenance	medications.

**Tier 2** is defined as Preferred Generic medications.

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## **Diabetic Program**

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#### 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



#### Gold 2750 HSA

# **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$2,750	\$8,250
Family	\$5,500	\$16,500
Out-of-Pocket Maximum		
Employee	\$2,750	\$28,350
Family	\$5,500	\$56,700
Physician Office Visits		
Illness/Injury	100%	80% RBP
Telemedicine	100%	80% RBP
Specialist Office Visits		
Illness/Injury	100%	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services	L	
As defined by		
the Affordable Care Act.	100%	80% RBP
See www.healthcare.gov for	100%	00% KBP
additional information.		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services	100%	80% RBP
(Labs, X-rays)		3070 1121
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.

Pediatric Dental and Vision (up to age 19) are included in this plan. Refer to certificate for full benefit details.

Note: If you have purchased a certified stand alone dental plan and provided an attestation to AultCare regarding that plan, coverage for pediatric dental, including a dental check-up, will be provided through that dental plan.

Not all benefit descriptions, exclusions and limitations are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificates of Coverage and Benefit Chart.

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



Prescription Drugs	Retail (34 Day Supply Unless Noted)	Mail Order (90 day supply)
Tier 1 - 1-60 day supply/Retail	\$0 Copayment	\$0 Copayment
Tier 2 - 1-60 day supply	100% Coinsurance	100% Coinsurance
Tier 3	100% Coinsurance	100% Coinsurance
Tier 4	100% Coinsurance	100% Coinsurance
Tier 5 and 6 - Prior Authorization is require		•
Specialty Networ	k pharmacy. Limited to a 30	day supply.
Tier 5	100% Coinsurance	N/A
Tier 6	100% Coinsurance	N/A

#### **Tier Definitions**

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

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**Tier 2** is defined as Preferred Generic medications.

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#### **Diabetic Program**

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- Microlet Lancets
- All generic Lancets



### **Gold 3150**

## **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network	Deductible and Ou  Maximum are Nor
Calendar Year Deductible			Therefore, Deduct
Employee	\$3,150	\$9,450	Pocket amounts m
Family	\$6,300	\$18,900	Providers <b>DO NOT</b> Deductible and Ou
. amy	<b>40,500</b>	Ψ10,300	amounts met for N
Out-of-Pocket Maximum			Providers.
Employee	\$4,750	\$28,350	Embedded Deduct
Family	\$9,500	\$56,700	member only need
			individual deductik
Physician Office Visits			receiving any bene
Illness/Injury	\$10 Copayment	70% RBP	Appropriate Dedu
Telemedicine	\$10 Copayment	70% RBP	satisfied before ar
			except as noted.
Specialist Office Visits	¢20 Canaumant	700/ DDD	The Out-of-Pocket
Illness/Injury	\$30 Copayment	70% RBP	amount includes the
Prescription Drugs	See Reverse side		Copayments and C
Trescription Drugs	See Neverse side		 Deductible is waiv
Preventive Health Services			Preventive Health
As defined by			Pediatric Dental ar
the Affordable Care Act.	1000/	700/ DDD	age 19) are include
See www.healthcare.gov for	100%	70% RBP	Refer to certificate
additional information.			details.
			Note: If you have p
Maternity Care	90%	70% RBP	certified stand alo
	000/	700/ 222	provided an attest
Inpatient Hospital Services	90%	70% RBP	regarding that plar pediatric dental, in
F	000/	000/ DDD	check-up, will be p
Emergency Services	90%	90% RBP	that dental plan.
Urgent Care	\$75 Copayment	\$75 Copayment RBP	Not all benefit des
	φ. σ σομαγσσ	<i>4.0 00 pa j</i>	exclusions and lim
Diagnostic Services	200/	700/ 222	included in this do
(Labs, X-rays)	90%	70% RBP	benefit description are contained in the
			Insurance Compan
Outpatient Therapy Services	90%	70% RBP	Coverage and Bend
			Contact AultCare
Other Services (Refer to	90%	70% RBP	www.aultcare.com
Summary Plan Description)			330-363-6360
Ambulance	90%	90% RBP	1-800-344-8858
Ambulance	30/0	30/0 NDP	
Annual Plan Maximum	UNLIMITED	UNLIMITED	コーニー
		0.1211111125	

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

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scriptions, nitations are ocument. Complete ns and exclusions he AultCare ny Certificates of nefit Chart.



Prescription Drugs	Retail (34 Day Supply Unless Noted)	Mail Order (90 day supply)	
Tier 1 - 1-60 day supply/Retail	\$0 Copayment	\$0 Copayment	
Tier 2 - 1-34 day supply	\$10 Copayment or 20%, greater of		
Tier 2 - 1-60 day supply/Retail	\$30 Copayment or 20%, greater of		
Tier 3	\$20 Copayment or 30%, greater of	\$55 Copayment or 25%, greater of	
Tier 4	\$45 Copayment or 40%, greater of	\$125 Copayment or 35%, greater of	
ier 5 and 6 - Prior Authorization is requ Specialty Netw	ired. Medications must be obtain ork pharmacy. Limited to a 30 d		
Tier 5	\$10 Copayment or 20%, greater of	N/A	
Tier 6	\$50 Copayment or 50%, greater of	N/A	

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