

# Platinum 250 Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	Deductible and Out-of-Pocket  Maximum are Non-Integrated.
			Therefore, Deductible and Out-of-
Calendar Year Deductible	4050	4750	Pocket amounts met for Network
Employee	\$250	\$750	Providers <b>DO NOT</b> apply to
Family	\$500	\$1,500	Deductible and Out-of-Pocket amounts met for Non-Network
Out-of-Pocket Maximum			Providers.
Employee	\$1,600	\$28,350	<del> </del>
Family	\$3,200	\$56,700	Embedded Deductible. Each family member only needs to meet his/her
Turniny	<b>\$3,200</b>	\$30,700	individual deductible prior to
Physician Office Visits			receiving any benefits.
Illness/Injury	\$20 Copayment	70% RBP	Annuarieta Dadustible must be
Telemedicine	\$20 Copayment	70% RBP	Appropriate Deductible must be satisfied before any benefit is paid
	• •		except as noted.
Specialist Office Visits			
Illness/Injury	\$40 Copayment	70% RBP	The Out-of-Pocket Maximum amount includes the Deductible,
			Copayments and Coinsurance.
Prescription Drugs	See Reverse side		
			Deductible is waived for Network
Preventive Health Services			Preventive Health Services.
As defined by			Pediatric Dental and Vision (up to
the Affordable Care Act.	100%	70% RBP	age 19) are included in this plan.
See www.healthcare.gov for			Refer to certificate for full benefit details.
additional information.			uetans.
Maternity Care	90%	70% RBP	Note: If you have purchased a
Materinty Care	90%	70% NBP	certified stand alone dental plan and
Inpatient Hospital Services	90%	70% RBP	provided an attestation to AultCare regarding that plan, coverage for
inpatient nospital services	3070	7070 KDI	pediatric dental, including a dental
Emergency Services	90%	90% RBP	check-up, will be provided through
zmergency certifies	30/0	30% N.D.	that dental plan.
Urgent Care	\$75 Copayment	\$75 Copayment RBP	Not all benefit descriptions,
			exclusions and limitations are
Diagnostic Services	90%	70% RBP	included in this document. Complete benefit descriptions and exclusions
(Labs, X-rays)	3070	70% KBF	are contained in the AultCare
			Insurance Company Certificates of
Outpatient Therapy Services	90%	70% RBP	Coverage and Benefit Chart.
Other Semines /Pefer to			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
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Annual Plan Maximum	UNLIMITED	UNLIMITED	$\neg$



	Retail		
Prescription Drugs	(34 Day Supply Unless	Mail Order (90 day supply)	
	Noted)		
Tier 1 -	\$0 Copayment	\$0 Copayment	
1-60 day supply/Retail	30 Copayment	30 сораунтент 	
Tier 2 -	\$10 Copayment or 20%,	\$30 Copayment or 20%,	
1-34 day supply	greater of	greater of	
Tier 2 -	\$30 Copayment or 20%,		
1-60 day supply/Retail	greater of		
Tier 3	\$20 Copayment or 30%,	\$55 Copayment or 25%,	
Her 3	greater of	greater of	
Tier 4	\$45 Copayment or 40%,	\$125 Copayment or 35%,	
Her 4	greater of	greater of	
Tier 5 and 6 - Prior Authorization is required. Medications must be obtained through an AultCare contracted			
Specialty Networ	k pharmacy. Limited to a 30	day supply.	
Tier 5	\$10 Copayment or 20%,	N/A	
Tier 5	greater of	IN/A	
Tier 6	\$50 Copayment or 50%,	N/A	
Her 6	greater of	IV/A	

### **Tier Definitions**

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

<b>Tier 1</b> is defined as Preventive Maintenance med	dications.
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**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



# Platinum 500 Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	Deductible and Out-of-Pocket
			Maximum are Non-Integrated.  Therefore, Deductible and Out-of-
Calendar Year Deductible			Pocket amounts met for Network
Employee	\$500	\$1,500	Providers <b>DO NOT</b> apply to
Family	\$1,000	\$3,000	Deductible and Out-of-Pocket
F			amounts met for Non-Network  Providers.
Out-of-Pocket Maximum			
Employee	\$1,300	\$28,350	Embedded Deductible. Each family
Family	\$2,600	\$56,700	member only needs to meet his/her
			individual deductible prior to receiving any benefits.
Physician Office Visits	4000	200/ 222	receiving any benefits.
Illness/Injury	\$20 Copayment	60% RBP	Appropriate Deductible must be
Telemedicine	\$20 Copayment	60% RBP	satisfied before any benefit is paid
			except as noted.
Specialist Office Visits	440.0	500/ 555	The Out-of-Pocket Maximum
Illness/Injury	\$40 Copayment	60% RBP	amount includes the Deductible,
<b>-</b>	Con Davisian side		Copayments and Coinsurance.
Prescription Drugs	See Reverse side		Dodustible is welled for Network
Duranantina Haalah Camiaaa			Deductible is waived for Network  Preventive Health Services.
Preventive Health Services			
As defined by			Pediatric Dental and Vision (up to
the Affordable Care Act.	100%	60% RBP	age 19) are included in this plan.
See www.healthcare.gov for			Refer to certificate for full benefit details.
additional information.			uetans.
Mataraity Cara	80%	60% RBP	Note: If you have purchased a
Maternity Care	ðU%	00% RBP	certified stand alone dental plan and
Inpatient Hospital Services	80%	60% RBP	provided an attestation to AultCare regarding that plan, coverage for
inpatient nospital services	<b>6</b> U%	00% KBP	pediatric dental, including a dental
Emarganov Sarvisas	900/	900/ DDD	check-up, will be provided through
Emergency Services	80%	80% RBP	that dental plan.
Hrgont Caro	\$75 Consument	\$75 Copayment RBP	Not all hangfit descriptions
Urgent Care	\$75 Copayment	373 Сораушент квг	Not all benefit descriptions, exclusions and limitations are
Diagnostic Services			included in this document. Complete
(Labs, X-rays)	80%	60% RBP	benefit descriptions and exclusions
(Labs, X-ruys)			are contained in the AultCare
Outpatient Therapy Services	80%	60% RBP	Insurance Company Certificates of Coverage and Benefit Chart.
Outpatient merapy services	8070	00% KBF	Coverage and Benefit Chart.
Other Services (Refer to			Contact AultCare
Summary Plan Description)	80%	60% RBP	www.aultcare.com
Summary Fluit Description)			330-363-6360
Ambulance	80%	80% RBP	1-800-344-8858
Ambulance	OU/0	0U/0 NDF	
Annual Plan Maximum	UNLIMITED	UNLIMITED	$\neg$
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	Retail	
Prescription Drugs	(34 Day Supply Unless	Mail Order (90 day supply)
	Noted)	
Tier 1 -	¢0 Consument	¢0 Congument
1-60 day supply/Retail	\$0 Copayment	\$0 Copayment
Tier 2 -	\$10 Copayment or 20%,	\$30 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 2 -	\$30 Copayment or 20%,	
1-60 day supply/Retail	greater of	
Tion 2	\$20 Copayment or 30%,	\$55 Copayment or 25%,
Tier 3	greater of	greater of
Tion 4	\$45 Copayment or 40%,	\$125 Copayment or 35%,
Tier 4	greater of	greater of
Tier 5 and 6 - Prior Authorization is req Specialty Net	uired. Medications must be obtain work 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	l as Preventive I	Maintenance	medications.
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**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



### Platinum 1150

### **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$1,150	\$3,450
Family	\$2,300	\$6,900
Out-of-Pocket Maximum	\$1,150	\$28,350
Employee Family	\$1,130	\$56,700
. u.i.i.y	<i>\$2,300</i>	<i>\$30,700</i>
Physician Office Visits		
Illness/Injury	\$20 Copayment	80% RBP
Telemedicine	\$20 Copayment	80% RBP
Specialist Office Visits		
Specialist Office Visits    Illness/Injury	\$40 Copayment	80% RBP
iiiiess, iijui y	7-10 Copayinent	OU/U INDE
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	80% RBP
See www.healthcare.gov for	20075	3373 1.121
additional information.		
Maternity Care	100%	80% RBP
· · · · · · · · · · · · · · · · · · ·		
Inpatient Hospital Services	100%	80% RBP
- · ·	4000/	4000/ PPP
Emergency Services	100%	100% RBP
Urgent Care	\$75 Copayment	\$75 Copayment RBP
Diagnostic Services	100%	80% RBP
Diagnostic services	100/0	OU/0 NDF
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to	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, Copayments 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 -	\$10 Copayment or 20%,	\$30 Copayment or 20%,	
1-34 day supply	greater of	greater of	
Tier 2 -	\$30 Copayment or 20%,		
1-60 day supply/Retail	greater of		
Tier 3	\$20 Copayment or 30%,	\$55 Copayment or 25%,	
rier 3	greater of	greater of	
Tier 4	\$45 Copayment or 40%,	\$125 Copayment or 35%,	
Her 4	greater of	greater of	
Tier 5 and 6 - Prior Authorization is required. Medications must be obtained through an AultCare contracted			
Specialty Networ	k pharmacy. Limited to a 30	day supply.	
Tier 5	\$10 Copayment or 20%,	NI/A	
Tier 5	greater of	N/A	
Tier 6	\$50 Copayment or 50%,	N/A	
Tier o	greater of	N/A	

### **Tier Definitions**

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

<b>Her 1</b> is defined as Preventive Maintenance medication	Tier 1	ned as Preventive Maintenance medi	cations	s.
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**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**

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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



# Platinum 1650 HSA 500

# **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		1
Employee	\$1,650	\$4,950
Family	\$3,300	\$9,900
Out-of-Pocket Maximum		
Employee	\$1,650	\$28,350
Family	\$3,300	\$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		
As defined by		
the Affordable Care Act.	1000/	000/ DDD
See www.healthcare.gov for	100%	80% RBP
additional information.		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services (Labs, X-rays)	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to Summary Plan Description)	100%	80% RBP
Ambulance	100%	100% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED

NOTE: Employer must contribute \$500 per Covered Person and \$1,000 per Family annually to each enrolled Employee's account. Attestation is required.

**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 required. Medications must be obtained through an AultCare contracted Specialty Network 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

is defined as Preferred Brand Specialty medications.

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.

### **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.

Tier 6