

## 90% High Option Plan **Schedule of Health Insurance Benefits**

**Medical Benefits** Network Non-Network Deductible and Out-of-Pocket **Calendar Year Deductible** Maximum are Non-Integrated. \$150 **Employee** \$300 Family \$300 \$600 Pocket amounts met for Network Providers **DO NOT** apply to Deductible and Out-of-Pocket **Out-of-Pocket Maximum** amounts met for Non-Network **Employee** \$500 \$1,000 Providers. **Family** \$1,000 \$2,000 Embedded Deductible. Each **Physician Office Visits and Telemedicine** to receiving any benefits. For Illness 90% 80% UCR 100% 100% UCR For Injury **Appropriate Deductible or** Copayment must be satisfied **Prescription Drugs** See Reverse side before any benefit is paid except as noted. **Preventive Health Services** Deductible Carrover. Amounts As defined by applied to the Deductible in the the Affordable Care Act. last three months of the calendar 100% 80% UCR year will be carried over to the See www.healthcare.gov for next calendar year. additional information. The Out-of-Pocket Maximum **Maternity Care** 90% 80% UCR amount includes the Deductible and Medical Coinsurance. Inpatient Hospital Services 90% 80% UCR Preventive Health Services. **Emergency Services** 100% 100% UCR Pre-Approval is recommended for all Inpatient admissions. **Urgent Care** 100% 100% UCR Not all benefit descriptions, exclusions and limitations are **Diagnostic Services** included in this document. 90% 80% UCR (Labs, X-rays) exclusions are contained in the AultCare Insurance Company **Outpatient Therapy Services** 90% 80% UCR Certificates of Coverage and Benefit Chart. **Other Services** Refer to Summary 90% 80% UCR Contact AultCare Plan Description www.aultcare.com 330-363-6360 1-800-344-8858 Ambulance 80% 80% UCR **Annual Plan Maximum UNLIMITED** UNLIMITED

Therefore, Deductible and Out-of-

family member only needs to meet his/her individual deductible prior

**Deductible is waived for Network** 

Complete benefit descriptions and



Prescription Drugs	Retail	Mail Order (60 day supply)		
Tier 1	\$10 Copayment or 20%,	\$27 Consument		
1-34 day supply	greater of	\$27 Copayment		
Tier 1	\$27 Copayment			
35-60 day supply	327 Copayment			
Tier 2	\$20 Copayment or 30%,	\$55 Copayment		
Her 2	greater of	355 Copayment		
Tier 3	\$45 Copayment or 50%,	\$110 Copayment		
Tier 5	greater of	\$110 Copayment		
Tier 4 and 5 - Prior Authorization is require	ed. Medications must be obtain	ed through an AultCare contracted		
Specialty Netwo	ork pharmacy. Limited to a 30 da	y supply.		
Tier 4	\$125 Copayment or 20%,	\$125 Copayment or 20%,		
Tiel 4	greater of	greater of		
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,		
Tier 5	greater of	greater of		
A thirty four (34) day supply is available at the retail pharmacy				
A sixty (60) day supply is available at the retail pharmacy for Tier 1				
A sixty (60) day supply may be obtained through the mail order program				

#### **Tier Definitions**

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

4				10
Tier 1	is defined as	Preferred	(zeneric	medications.

**Tier 2** is defined as Preferred Brand and Non-Preferred Generic medications.

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

**Tier 4** is defined as Specialty Generic medications.

**Tier 5** is defined as Specialty Brand medications.

## **Diabetic Program**

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

## Products covered for \$0 Copayment through your Pharmacy Benefit

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



## 80% Plan - Option I

## **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network	_
Calendar Year Deductible			Deductible and Out-of-Pocket
Employee	\$200	\$200	Maximum are Integrated.
Family	\$400	\$400	Therefore, Deductible and Out-of-
Tulliny	3400	ÿ400	Pocket amounts met for Network Providers also apply to Deductible
Out-of-Pocket Maximum			and Out-of-Pocket amounts met
	¢600	¢1 400	for Non-Network Providers.
Employee	\$600	\$1,400	Embedded Deductible. Each
Family	\$1,200	\$2,800	family member only needs to mee
			his/her individual deductible prior
Physician Office Visits and Telemedi			to receiving any benefits.
For Illness	80%	60% UCR	Appropriate Deductible or
For Injury	100%	100% UCR	Copayment must be satisfied
			before any benefit is paid except
Prescription Drugs	See Reverse side		as noted.
r			Deductible Carryover. Amounts
Preventive Health Services			applied to the Deductible in the
As defined by			last three months of the calendar year will be carried over to the
the Affordable Care Act.	100%	60% UCR	next calendar year.
See www.healthcare.gov for			, in the second
additional information.			The Out-of-Pocket Maximum
			amount includes the Deductible
Maternity Care	80%	60% UCR	and Medical Coinsurance.
			Deductible is waived for Network
Inpatient Hospital Services	80%	60% UCR	Preventive Health Services.
Emergency Services	100%	100% UCR	Pre-Approval is recommended for
Lineigency Services	10070	100% OCK	all Inpatient admissions.
Urgent Care	100%	100% UCR	Not all benefit descriptions,
			exclusions and limitations are included in this document.
Diagnostic Services			Complete benefit descriptions and
(Labs, X-rays)	80%	60% UCR	exclusions are contained in the
(2005) 11 10/5/			AultCare Insurance Company Certificates of Coverage and
Outpatient Therapy Services	80%	60% UCR	Benefit Chart.
очервием постару селинее		3373 3311	
Other Services Refer to Summary			Contact AultCare  www.aultcare.com
Plan Description	80%	60% UCR	330-363-6360
rian Description			1-800-344-8858
Ambulance	80%	80% UCR	
Annual Plan Maximum	UNLIMITED	UNLIMITED	



Prescription Drugs	Retail	Mail Order (60 day supply)		
Tier 1	\$10 Copayment or 20%,	\$27 Consument		
1-34 day supply	greater of	\$27 Copayment		
Tier 1	\$27 Consument			
35-60 day supply	\$27 Copayment			
Tier 2	\$20 Copayment or 30%,	\$55 Copayment		
Tiel 2	greater of	333 сораунтент		
Tier 3	\$45 Copayment or 50%,	¢110 Consument		
Tier 5	greater of	\$110 Copayment		
Tier 4 and 5 - Prior Authorization is require	ed. Medications must be obtain	ed through an AultCare contracted		
Specialty Netwo	rk pharmacy. Limited to a 30 da	y supply.		
Tier 4	\$125 Copayment or 20%,	\$125 Copayment or 20%,		
Her 4	greater of	greater of		
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,		
Tier 5	greater of	greater of		
A thirty four (34) day supply is available at the retail pharmacy				
A sixty (60) day supply is available at the retail pharmacy for Tier 1				
A sixty (60) day supply may be obtained through the mail order program				

#### **Tier Definitions**

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

**Tier 2** is defined as Preferred Brand and Non-Preferred Generic medications.

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

**Tier 4** is defined as Specialty Generic medications.

**Tier 5** is defined as Specialty Brand medications.

#### **Diabetic Program**

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

### Products covered for \$0 Copayment through your Pharmacy Benefit

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



## 80% Plan - Option II

## **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network	
Calendar Year Deductible			Deductible and Out-of-Pocket
Employee	\$300	\$300	Maximum are Integrated.
Family	\$600	\$600	Therefore, Deductible and Out-of-
Turmy	\$000	3000	Pocket amounts met for Network  Providers also apply to Deductible
Out-of-Pocket Maximum			and Out-of- Pocket amounts met
Employee	\$1,300	\$2,300	for Non-Network Providers.
Family	\$2,600	\$4,600	Embedded Deductible. Each
Funny	\$2,000	\$4,000	family member only needs to mee
Physician Office Visits and Telemed	icino		his/her individual deductible prior
For Illness		60% HCB	to receiving any benefits.
	80%	60% UCR	Appropriate Deductible or
For Injury	100%	100% UCR	Copayment must be satisfied
[a a ]			before any benefit is paid except as noted.
Prescription Drugs	See Reverse side		as noted.
			Deductible Carryover. Amounts
Preventive Health Services			applied to the Deductible in the last three months of the calendar
As defined by			year will be carried over to the
the Affordable Care Act.	100%	60% UCR	next calendar year.
See www.healthcare.gov for			
additional information.			The Out-of-Pocket Maximum amount includes the Deductible
Indiana di Constanti di Constan	200/	C00/ LICD	and Medical Coinsurance.
Maternity Care	80%	60% UCR	
	200/	600/ 1160	Deductible is waived for Network
Inpatient Hospital Services	80%	60% UCR	Preventive Health Services.
F	1000/	1000/ LICD	Pre-Approval is recommended for
Emergency Services	100%	100% UCR	all Inpatient admissions.
Hrgant Cara	100%	100% UCR	Not all benefit descriptions,
Urgent Care	100%	100% OCK	exclusions and limitations are
[n·			included in this document.  Complete benefit descriptions and
Diagnostic Services	80%	60% UCR	exclusions are contained in the
(Labs, X-rays)			AultCare Insurance Company
[a	200/	600/ 1100	Certificates of Coverage and Benefit Chart.
Outpatient Therapy Services	80%	60% UCR	benefit Chart.
			Contact AultCare
Other Services Refer to Summary	80%	60% UCR	www.aultcare.com
Plan Description			330-363-6360 1-800-344-8858
[	000/	000/1100	
Ambulance	80%	80% UCR	
Annual Dian Mayirra			$\neg$
Annual Plan Maximum	UNLIMITED	UNLIMITED	



Prescription Drugs	Retail	Mail Order (60 day supply)		
Tier 1 1-34 day supply	\$10 Copayment or 20%, greater of	\$27 Copayment		
Tier 1 35-60 day supply	\$27 Copayment			
Tier 2	\$20 Copayment or 30%, greater of	\$55 Copayment		
Tier 3	\$45 Copayment or 50%, greater of	\$110 Copayment		
Tier 4 and 5 - Prior Authorization is require	ed. Medications must be obtain	ed through an AultCare contracted		
Specialty Netwo	rk pharmacy. Limited to a 30 da	y supply.		
Tier 4	\$125 Copayment or 20%, greater of	\$125 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 sixty (60) day supply may be obtained through the mail order program				

#### **Tier Definitions**

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

Tier 1	ic dofined a	C Droforrod	Conoric r	nedications.
Hel T	is defilled a	s Preierreu '	Genenc i	neuications.

**Tier 2** is defined as Preferred Brand and Non-Preferred Generic medications.

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

**Tier 4** is defined as Specialty Generic medications.

**Tier 5** is defined as Specialty Brand medications.

## **Diabetic Program**

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

## Products covered for \$0 Copayment through your Pharmacy Benefit

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



## 80% Plan - Option III Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$500	\$500
Family	\$1,000	\$1,000
Out-of-Pocket Maximum		
Employee	\$1,500	\$2,500
Family	\$3,000	\$5,000
Physician Office Visits and Telemed	dicine	
For Illness	80%	60% UCR
For Injury	100%	100% UCR
Prescription Drugs	80% (after Network Deductible)	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	60% UCR
Maternity Care	80%	60% UCR
Inpatient Hospital Services	80%	60% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services (Labs, X-rays)	80%	60% UCR
Outpatient Therapy Services	80%	60% UCR
Other Services Refer to Summary Plan Description	80%	60% UCR
Ambulance	80%	80% UCR
Annual Plan Maximum	UNLIMITED	UNLIMITED

## Deductible and Out-of-Pocket Maximum are Integrated.

Therefore, Deductible and Out-of-Pocket amounts met for Network Providers also 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.

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

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



## \$750/\$1500 Plan

## **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network	
Calendar Year Deductible			Deductible and Out-of-Pocket
Employee	\$750	\$1,500	Maximum are Non-Integrated.
Family	\$1,500	\$3,000	Therefore, Deductible and Out-of- Pocket amounts met for Network
-			Providers <b><u>DO NOT</u></b> apply to
Out-of-Pocket Maximum			Deductible and Out-of-Pocket
Employee	\$3,000	\$6,000	amounts met for Non-Network  Providers.
Family	\$6,000	\$12,000	
,	1 37 3 3	1 /	Embedded Deductible. Each
<b>Physician Office Visits and Telemedi</b>	icine		family member only needs to meet his/her individual deductible prior
For Illness	\$25 Copayment	60% UCR	to receiving any benefits.
For Injury	100%	100% UCR	
13,,	100/0	100/0 0011	Appropriate Deductible or Copayment must be satisfied
Prescription Drugs	See Reverse side		before any benefit is paid except
rescription brugs	See Neverse side		as noted.
Preventive Health Services			Deductible Carryover. Amounts
As defined by			applied to the Deductible in the
the Affordable Care Act.			last three months of the calendar
See www.healthcare.gov for	100%	60% UCR	year will be carried over to the
additional information.			next calendar year.
,			The Out-of-Pocket Maximum
Maternity Care	80%	60% UCR	amount includes the Deductible
,			and Medical Coinsurance.
Inpatient Hospital Services	80%	60% UCR	Deductible is waived for Network
process and the second			Preventive Health Services.
Emergency Services	\$50 Copayment	100% UCR	Pre-Approval is recommended for
	to colonium		all Inpatient admissions.
Urgent Care	\$25 Copayment	100% UCR	
0.80	<i>+10 00pa</i> ,	200/0 00.1	Not all benefit descriptions, exclusions and limitations are
Diagnostic Services			included in this document.
(Labs, X-rays)	80%	60% UCR	Complete benefit descriptions and
(Lubs, A-ruys)			exclusions are contained in the
Outpatient Therapy Services	80%	60% UCR	AultCare Insurance Company Certificates of Coverage and
Outpatient Therapy Services	80%	00% UCK	Benefit Chart.
Other Services Refer to Summary	1		
1	80%	60% UCR	Contact AultCare www.aultcare.com
Plan Description			330-363-6360
Ambulance	80%	80% UCR	1-800-344-8858
Ambulance	OU/0	0U/0 UCK	
Annual Plan Maximum	UNLIMITED	UNLIMITED	
Allitudi Fidil ividxilliUlli	UNLIIVIITED	UNLIMITED	



Prescription Drugs	Retail	Mail Order (60 day supply)		
Tier 1	\$10 Copayment or 20%,	\$27 Consument		
1-34 day supply	greater of	\$27 Copayment		
Tier 1	\$27 Consument			
35-60 day supply	\$27 Copayment			
Tier 2	\$20 Copayment or 30%,	¢EE Consument		
Her 2	greater of	\$55 Copayment		
Tier 3	\$45 Copayment or 50%,	¢110 Consument		
Tier 3	greater of	\$110 Copayment		
Tier 4 and 5 - Prior Authorization is require	ed. Medications must be obtain	ed through an AultCare contracted		
Specialty Netwo	rk pharmacy. Limited to a 30 da	y supply.		
Tier 4	\$125 Copayment or 20%,	\$125 Copayment or 20%,		
ner 4	greater of	greater of		
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,		
Tier 5	greater of	greater of		
A thirty four (34) day supply is available at the retail pharmacy				
A sixty (60) day supply is available at the retail pharmacy for Tier 1				
A sixty (60) day supply may be obtained through the mail order program				

### **Tier Definitions**

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

- **Tier 1** is defined as Preferred Generic medications.
- **Tier 2** is defined as Preferred Brand and Non-Preferred Generic medications.
- **Tier 3** is defined as Non-Preferred Brand and Non-Preferred Generic medications.
- **Tier 4** is defined as Specialty Generic medications.
- **Tier 5** is defined as Specialty Brand medications.

#### **Diabetic Program**

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

## Products covered for \$0 Copayment through your Pharmacy Benefit

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



## Group Purchasing Plan I Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	
			<del></del>
Calendar Year Deductible			Deductible and Out-of-Pocket
Employee	\$100	\$300	Maximum are Non-Integrated.  Therefore, Deductible and Out-of-
Family	\$300	\$900	Pocket amounts met for Network
Out-of-Pocket Maximum			Providers <b>DO NOT</b> apply to  Deductible and Out-of-Pocket
Employee	\$600	\$2,050	amounts met for Non-Network
Family	\$1,500	\$6,150	Providers.
			Embedded Deductible. Each
Physician Office Visits and Telemedi	cine		family member only needs to meet
For Illness	\$10 Copayment	65% UCR	his/her individual deductible prior to receiving any benefits.
For Injury	100%	100% UCR	to reserving any sements.
OB/GYN	\$5 Copayment		Appropriate Deductible or
			Copayment must be satisfied before any benefit is paid except
Prescription Drugs	See Reverse side		as noted.
			Deductible Carryover. Amounts
Preventive Health Services			applied to the Deductible in the
As defined by			last three months of the calendar
the Affordable Care Act.	100%	65% UCR	year will be carried over to the next calendar year.
See www.healthcare.gov for additional information.			, , ,
dualtional information.			The Out-of-Pocket Maximum amount includes the Deductible
Banka unitar Carra	000/	CEN/ LICE	and Medical Coinsurance.
Maternity Care	90%	65% UCR	
Inpatient Hospital Services	90%	65% UCR	Deductible is waived for Network Preventive Health Services.
inpatient nospital services	3070	03/0 0611	
Emergency Services	100%	100% UCR	Pre-Approval is recommended for all Inpatient admissions.
		20070 00.1	an impatient damissions.
Urgent Care	100%	100% UCR	Not all benefit descriptions,
	L		exclusions and limitations are included in this document.
Diagnostic Services			Complete benefit descriptions and
(Labs, X-rays)	90%	65% UCR	exclusions are contained in the  AultCare Insurance Company
,	<u>,                                    </u>		Certificates of Coverage and
Outpatient Therapy Services	90%	65% UCR	Benefit Chart.
			Contact AultCare
Other Services Refer to Summary	00%	CEO/ LICE	www.aultcare.com
Plan Description	90%	65% UCR	330-363-6360
			1-800-344-8858
Ambulance	80%	80% UCR	
<u> </u>			
Annual Plan Maximum	UNLIMITED	UNLIMITED	



Prescription Drugs	Retail	Mail Order (60 day supply)		
Tier 1	\$10 Copayment or 20%,	\$27 Copayment		
1-34 day supply	greater of	727 Copayment		
Tier 1	\$27 Copayment			
35-60 day supply	327 Copayment			
Tier 2	\$20 Copayment or 30%,	¢FF Consument		
	greater of	\$55 Copayment		
Tier 3	\$45 Copayment or 50%,	¢110 Canaymant		
	greater of	\$110 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	\$125 Copayment or 20%,	\$125 Copayment or 20%,		
	greater of	greater of		
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,		
	greater of	greater of		
A thirty four (34) day supply is available at the retail pharmacy				
A sixty (60) day supply is available at the retail pharmacy for Tier 1				
A sixty (60) day supply may be obtained through the mail order program				

#### **Tier Definitions**

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

Tier 1	is defined as	Droforrod (	Canaria ma	dications
Hel T	is defilied as	s Preferreu (	Jenenc me	dications.

**Tier 2** is defined as Preferred Brand and Non-Preferred Generic medications.

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

**Tier 4** is defined as Specialty Generic medications.

**Tier 5** is defined as Specialty Brand medications.

## **Diabetic Program**

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

### Products covered for \$0 Copayment through your Pharmacy Benefit

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



# Group Purchasing Plan III Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	
Calendar Year Deductible			Deductible and Out-of-Pocket
	\$200	\$450	Maximum are Non-Integrated.
Employee	· ·	•	Therefore, Deductible and Out-of-
Family	\$400	\$900	Pocket amounts met for Network
			Providers <u>DO NOT</u> apply to  Deductible and Out-of-Pocket
Out-of-Pocket Maximum			amounts met for Non-Network
Employee	\$700	\$1,950	Providers.
Family	\$1,400	\$3,900	
<u> </u>	<u>.</u>		Embedded Deductible. Each
Physician Office Visits and Telemed	icine		family member only needs to meet his/her individual deductible prior
For Illness	\$10 Copayment	70% UCR	to receiving any benefits.
For Injury	100%	100% UCR	
FOI IIIJUIY	100%	100% OCK	Appropriate Deductible or
[			Copayment must be satisfied
Prescription Drugs	See Reverse side		before any benefit is paid except as noted.
Preventive Health Services			Deductible Carryover. Amounts
As defined by			applied to the Deductible in the
the Affordable Care Act.	1000/	700/ 1100	last three months of the calendar
See www.healthcare.gov for	100%	70% UCR	year will be carried over to the next calendar year.
additional information.			next calendar year.
,			The Out-of-Pocket Maximum
Maternity Care	90%	70% UCR	amount includes the Deductible
Materinty care	30%	7070 0011	and Medical Coinsurance.
Inpatient Hospital Services	90%	70% UCR	Deductible is waived for Network
р.ш.е	3 3 7 2		Preventive Health Services.
Emergency Services	100%	100% UCR	Dur Assessation consequently
Efficigency Services	10070	100% OCK	Pre-Approval is recommended for all Inpatient admissions.
Urgent Care	100%	100% UCR	
orgent care	10070	100% GER	Not all benefit descriptions,
<u></u>			exclusions and limitations are
Diagnostic Services	90%	70% UCR	included in this document.  Complete benefit descriptions and
(Labs, X-rays)			exclusions are contained in the
			AultCare Insurance Company
Outpatient Therapy Services	90%	70% UCR	Certificates of Coverage and
			Benefit Chart.
Other Services Refer to Summary	2001	<b>3061:135</b>	Contact AultCare
Plan Description	90%	70% UCR	www.aultcare.com
Sessiption			330-363-6360
Ambulanco	80%	80% UCR	1-800-344-8858
Ambulance	δ0//0	8U% UCK	
[			
Annual Plan Maximum	UNLIMITED	UNLIMITED	



Prescription Drugs	Retail	Mail Order (60 day supply)		
Tier 1	\$10 Copayment or 20%,	\$27 Copayment		
1-34 day supply	greater of	727 Copayment		
Tier 1	\$27 Copayment			
35-60 day supply	327 Copayment			
Tier 2	\$20 Copayment or 30%,	¢FF Consument		
	greater of	\$55 Copayment		
Tier 3	\$45 Copayment or 50%,	¢110 Canaymant		
	greater of	\$110 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	\$125 Copayment or 20%,	\$125 Copayment or 20%,		
	greater of	greater of		
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,		
	greater of	greater of		
A thirty four (34) day supply is available at the retail pharmacy				
A sixty (60) day supply is available at the retail pharmacy for Tier 1				
A sixty (60) day supply may be obtained through the mail order program				

#### **Tier Definitions**

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

T' 4				
Tier 1	is detined	as Preferred	ı 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