

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 I	Preterred	(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		2012 2011	, in the second 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	100/0	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.
очервиено пистору селинос		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		LINILINAITED	\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 <u>DO NOT</u> 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
Physician Office Visits and Telemedi	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
принене пеориал останов	30,7	00,000	Preventive Health Services.
Emergency Services	\$50 Copayment	100% UCR	Pre-Approval is recommended for
	too coba,e	200/0 00.1	all Inpatient admissions.
Urgent Care	\$25 Copayment	100% UCR	
organic care	ψ25 copαγet	100/0 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
Outpotiont Thomas Commisses	80%	60% UCR	AultCare Insurance Company Certificates of Coverage and
Outpatient Therapy Services	80%	00% UCK	Benefit Chart.
Other Services Refer to Summary	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	LINILIMITED	LINILINAITED	
AIIIIUAI FIAII IVIAXIIIIUIII	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%,	¢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	
			
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 DO NOT 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 suppl		
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%,	SEE Consument	
Her 2	greater of	\$55 Copayment	
Tier 3	\$45 Copayment or 50%,	¢110 Canaymant	
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	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



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	
roi injury	100/0	100/0 UCN	Appropriate Deductible or
<u></u>			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.	100%	70% UCR	last three months of the calendar year will be carried over to the
See www.healthcare.gov for	100%	70% OCK	next calendar year.
additional information.			
			The Out-of-Pocket Maximum
Maternity Care	90%	70% UCR	amount includes the Deductible
<u> </u>	- !-		and Medical Coinsurance.
Inpatient Hospital Services	90%	70% UCR	Deductible is waived for Network
inputient Hospital Sel vices	30%	7070 0011	Preventive Health Services.
Emergency Services	100%	100% UCR	
Lineigency Services	10076	100% GEN	Pre-Approval is recommended for all Inpatient admissions.
Humant Cara	1000/	1000/ LICE	
Urgent Care	100%	100% UCR	Not all benefit descriptions,
			exclusions and limitations are
Diagnostic Services	90%	70% UCR	included in this document. Complete benefit descriptions and
(Labs, X-rays)	30%	7070 0011	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			Contact AultCare
Plan Description	90%	70% UCR	www.aultcare.com
ran bescription			330-363-6360
Ambulanca	900/	900/ LICD	1-800-344-8858
Ambulance	80%	80% UCR	
T	T		
Annual Plan Maximum	UNLIMITED	UNLIMITED	



Prescription Drugs	Retail Mail Order (60 day suppl		
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%,	SEE Consument	
Her 2	greater of	\$55 Copayment	
Tier 3	\$45 Copayment or 50%,	¢110 Canaymant	
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

4			10
Tier 1	is defined as Prefer	red (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



Aulternative 2000 E HDHP - HSA Compatible Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network		
Calendar Year Deductible	40.000	1 44.000		
Employee	\$2,000	\$4,000		
Family	\$4,000	\$8,000		
Out-of-Pocket Maximum				
Employee	\$2,000	\$8,000		
Family	\$4,000	\$16,000		
Prescription Drug Out-of-Pocket M	aximum Separate from Me	edical		
Employee	\$500	N/A		
Family	\$1,000	N/A		
Physician Office Visits and Talamas	diain a			
Physician Office Visits and Telemed	100%	80% UCR		
	100%	100% UCR		
For Injury	100%	100% OCK		
Prescription Drugs	See Reverse side			
Preventive Health Services				
As defined by				
the Affordable Care Act.				
See www.healthcare.gov for	100%	50% UCR		
additional information.				
Maternity Care	100%	80% UCR		
Inpatient Hospital Services	100%	80% UCR		
Emergency Services	100%	100% UCR		
Urgent Care	100%	100% UCR		
Diagnostic Services	100%	80% UCR		
(Labs, X-rays)		3075 00.1		
Outpatient Therapy Services	100%	80% UCR		
Other Services (Refer to Summary	100%	80% UCR		
Plan Description)	100/0	50/0 OCIV		
Ambulance	100%	100% UCR		
Annual Plan Maximum	UNLIMITED	UNLIMITED		

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

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

Unembedded Deductible. Entire family deductible must be met before any plan payments are made for any individual family member.

Appropriate Deductible must be satisfied before any benefit is paid except as noted.

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

Once the Medical Plan Deductible /Out-of-Pocket amount is met, there is an additional Pharmacy Out-of-Pocket amount which includes Pharmacy Copayments and Coinsurance. Once this Maximum is met, Prescription cost share will be waived.

Deductible is waived for Network Preventive Health Services.

Pre-Approval is recommended for all Inpatient admissions.

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

Contact AultCare

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



Prescription Copayments and Coinsurance apply after medical Deductible of \$2,000 per covered person or \$4,000 per family is met.

Prescription Drugs	Retail	Mail Order (60 day supply)			
Tier 1 1-34 day supply	\$10 Copayment	\$27 Copayment			
Tier 1 35-60 day supply	\$20 Copayment				
Tier 2	\$30 Copayment	\$72 Copayment			
Tier 3	\$60 Copayment or 50%, greater of	\$145 Copayment			
Tier 4 and 5 - Prior Authorization is requ	uired. Medications must be o	btained through an AultCare			
contracted Specialty Net	work pharmacy Limited to a	30 day supply.			
Tier 4	Tier 4 \$27 Copayment \$27 Copayment				
Tier 5	\$72 Copayment	\$72 Copayment			
	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					

No prescription Copayments after an additional Prescription Out-of-Pocket of \$500 per covered person or \$1,000 per family is met.

Tier Definitions

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

Tier 1 is defined as Preferred Generic medication	Tier 1	is defined	l as Preferred	Generic med	dications.
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Tier 2 is defined as Preferred Brand and Non-Preferred Generic medications.

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

Tier 4 is defined as Specialty Generic medications.

Tier 5 is defined as Specialty Brand medications.

Diabetic Program

Diabetic testing supplies are available to you through your pharmacy plan. You will be eligible for a CONTOUR NEXT ONE blood glucose meter and all related blood glucose testing supplies for \$0 Copayment.

To order your free meter, call 1-800-401-8440, code CTR-OPX.

Products covered for \$0 Copayment through your Pharmacy Benefit

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



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

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$5,000	\$7,500
Family	\$10,000	\$15,000
Out-of-Pocket Maximum		
Employee	\$5,000	\$10,000
Family	\$10,000	\$20,000
Physician Office Visits and Telemedic	ine	
For Illness	100%	80% UCR
For Injury	100%	100% UCR
Prescription Drugs (Follow Premium Managed Formulary)	100%	
Fremium Managea Formalary)		
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% UCR
See www.healthcare.gov for	100/0	30% OCK
additional information.		
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services	100%	80% UCR
(Labs, X-rays)		
Outpatient Therapy Services	100%	80% UCR
Other Services (Refer to Summary Plan Description)	100%	80% UCR
Ambulance	100%	100% UCR
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, 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



Aulternative 1000/100 C Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$1,000	\$2,000
Family	\$2,000	\$4,000
Out-of-Pocket Maximum		
Employee	\$1,000	\$4,000
Family	\$2,000	\$8,000
Physician Office Visits and Telemedic	cine	
For Illness	100%	80% UCR
For Injury	100%	100% UCR
Prescription Drugs (Follow Premium Managed Formulary)	100%	
Preventive Health Services		
As defined by		
the Affordable Care Act.	1000/	F00/ LICD
See www.healthcare.gov for	100%	50% UCR
additional information.		
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
e-Berne care	100%	100/0 OCK
Diagnostic Services	100%	80% UCR
(Labs, X-rays)		33,3 331
Outpatient Therapy Services	100%	80% UCR
Other Services (Refer to Summary Plan Description)	100%	80% UCR
Ambulance	100%	100% UCR
Annual Plan Maximum	UNLIMITED	UNLIMITED
		1

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

Embedded Deductible. Each family member only needs to meet his/her individual deductible prior to receiving any benefits.

Appropriate Deductible 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 and exclusions are included in this document. Complete benefit descriptions and exclusions are contained in the AultCare Insurance Company Certificate of Coverage which will govern.

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



Aulternative 1000/80 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	=
Calendar Year Deductible			Deductible and Out-of-Pocket
Employee	\$1,000	\$2,000	Maximum are Non-Integrated.
Family	\$2,000	\$4,000	Therefore, Deductible and Out-of-
Fullilly	\$2,000	34,000	Pocket amounts met for Network Providers DO NOT apply to
Out-of-Pocket Maximum			Deductible and Out-of-Pocket amounts met for Non-Network
Employee	\$2,000	\$4,000	Providers.
Family	\$4,000	\$8,000	
·			Embedded Deductible. Each family member only needs to meet
Physician Office Visits and Telemedi	cine		his/her individual deductible prior
For Illness	\$25 Copayment	60% UCR	to receiving any benefits.
For Injury	\$25 Copayment	\$25 Copayment UCR	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		T	applied to the Deductible in the
the Affordable Care Act.	4000/	500/ 1100	last three months of the calendar
See www.healthcare.gov for	100%	50% UCR	year will be carried over to the next calendar year.
additional information.			next calcinaar year.
			The Out-of-Pocket Maximum
Maternity Care	80%	60% UCR	amount includes the Deductible and Medical Coinsurance.
•			and Medical Comsulance.
Inpatient Hospital Services	80%	60% UCR	Deductible is waived for Network
<u> </u>		•	Preventive Health Services.
Emergency Services	\$50 Copayment	\$50 Copayment UCR	Pre-Approval is recommended for
	·		all Inpatient admissions.
Urgent Care	\$25 Copayment	\$25 Copayment UCR	Not all be a first description
		· · · · · · · · · · · · · · · · · · ·	Not all benefit descriptions, exclusions and limitations are
Diagnostic Services			included in this document.
(Labs, X-rays)	80%	60% UCR	Complete benefit descriptions and
(1-000) // (1-000)			exclusions are contained in the AultCare Insurance Company
Outpatient Therapy Services	80%	60% UCR	Certificates of Coverage and
Suspending Therapy Services	0070	00% 00%	Benefit Chart.
Other Services Refer to Summary		1	Contact AultCare
Plan Description	80%	60% UCR	www.aultcare.com
. ia.i Sescription		<u> </u>	330-363-6360
Ambulance	80%	80% UCR	1-800-344-8858
, in addition	5070	1 0070 0011	_
Annual Plan Maximum	UNLIMITED	UNLIMITED	
Annual Flan Maxillani	CIVELIVITIED	ONLIMITED	



Prescription Drugs	Retail Mail Order (60 day supply)		
Tier 1	\$10 Copayment or 20%, \$27 Copayment		
1-34 day supply	greater of	327 Copayment	
Tier 1	\$27 Canaymant		
35-60 day supply	\$27 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	3110 Copayment	
Tier 4 and 5 - Prior Authorization is require	Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted		
Specialty Netwo	k pharmacy. Limited to a 30 da	y supply.	
Tier 4	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
1161 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 availability

Tier 1	is defined as Preferred Generic medications.
Her I	is defined as Freierred defield inedications.

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.

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



Aulternative 1000/100 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	=
Calendar Year Deductible			Deductible and Out-of-Pocket
	Ć1 000		Maximum are Non-Integrated.
Employee	\$1,000	\$2,000	Therefore, Deductible and Out-of-
Family	\$2,000	\$4,000	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	\$1,000	\$4,000	Providers.
Family	\$2,000	\$8,000	
		•	Embedded Deductible. Each family member only needs to meet
Physician Office Visits and Telemed	icine		his/her individual deductible prior
For Illness	\$25 Copayment	80% UCR	to receiving any benefits.
For Injury	\$25 Copayment	\$25 Copayment UCR	┪
1 of Injury	723 copayment	723 copayment ock	Appropriate Deductible or
Decement on Decemen	See Reverse side		Copayment must be satisfied before any benefit is paid except
Prescription Drugs	See Reverse side		as noted.
			\neg
Preventive Health Services			Deductible Carryover. Amounts
As defined by			applied to the Deductible in the last three months of the calendar
the Affordable Care Act.	100%	50% UCR	year will be carried over to the
See www.healthcare.gov for			next calendar year.
additional information.			
			The Out-of-Pocket Maximum amount includes the Deductible
Maternity Care	100%	80% UCR	and Medical Coinsurance.
Inpatient Hospital Services	100%	80% UCR	Deductible is waived for Network
<u> </u>			Preventive Health Services.
Emergency Services	\$50 Copayment	\$50 Copayment UCR	Pre-Approval is recommended for
	• • •	· · · /	all Inpatient admissions.
Urgent Care	\$25 Copayment	\$25 Copayment UCR	Not all be a fit description
	• •		Not all benefit descriptions, exclusions and limitations are
Diagnostic Services			included in this document.
(Labs, X-rays)	100%	80% UCR	Complete benefit descriptions and
(Lubs, X-ruys)			exclusions are contained in the
Outrotions Thomas Control	4000/	000/1105	AultCare Insurance Company Certificates of Coverage and
Outpatient Therapy Services	100%	80% UCR	Benefit Chart.
Other Comises B. C. C.			7
Other Services Refer to Summary	100%	80% UCR	Contact AultCare
Plan Description			www.aultcare.com 330-363-6360
T			1-800-344-8858
Ambulance	100%	100% UCR	
[a			\neg
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	327 Copayment			
Tier 1	\$27 Copayment				
35-60 day supply	327 Copayment				
Tier 2	\$20 Copayment or 30%,	\$55 Copayment			
HEI Z	greater of	333 copayment			
Tier 3	\$45 Copayment or 50%,	\$110 Copayment			
Hel 3	greater of	3110 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%,			
Her 4	greater of	greater of			
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,			
Her 5	greater of	greater of			
A thirty four (34) day supply is available at the 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 availability

Tier 1	is defined	as Preferred	Generic	medications
1161 1	is defined	as Freiencu	Generic	meaicanons.

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.

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



Aulternative 1500/90 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	=
Calendar Year Deductible			Deductible and Out-of-Pocket
Employee	\$1,500	\$3,000	Maximum are Non-Integrated.
Family	\$3,000	\$6,000	Therefore, Deductible and Out-of-
Fullilly	73,000	\$0,000	Pocket amounts met for Network Providers DO NOT apply to
Out-of-Pocket Maximum			Deductible and Out-of-Pocket
Employee	\$2,500	\$6,000	amounts met for Non-Network Providers.
Family	\$5,000	\$12,000	Troviders.
. Gilliny	ψ3,000	V12,000	Embedded Deductible. Each
Physician Office Visits and Telemed	icine		family member only needs to meet his/her individual deductible prior
For Illness	\$25 Copayment	70% UCR	to receiving any benefits.
For Injury	\$25 Copayment	\$25 Copayment UCR	
r or mjury	723 copayment	\$23 copayment och	Appropriate Deductible or Copayment must be satisfied
Prescription Drugs	See Reverse side		before any benefit is paid except
Trescription Drugs	See Neverse side		as noted.
Preventive Health Services			Deductible Carryover. Amounts
As defined by		T	applied to the Deductible in the
the Affordable Care Act.	4000/	500/1100	last three months of the calendar
See www.healthcare.gov for	100%	50% 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
•			and Medical Coinsurance.
Inpatient Hospital Services	90%	70% UCR	Deductible is waived for Network
-			Preventive Health Services.
Emergency Services	\$150 Copayment	\$150 Copayment UCR	Pre-Approval is recommended for
		•	all Inpatient admissions.
Urgent Care	\$50 Copayment	\$50 Copayment UCR	Not all benefit descriptions,
			exclusions and limitations are
Diagnostic Services	000/	700/1100	included in this document.
(Labs, X-rays)	90%	70% UCR	Complete benefit descriptions and
<u> </u>			 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	0.051		Contact AultCare
Plan Description	90%	70% UCR	www.aultcare.com
,		•	330-363-6360
Ambulance	90%	90% UCR	1-800-344-8858
			<u> </u>
Annual Plan Maximum	UNLIMITED	UNLIMITED	



Prescription Drugs	tion Drugs Retail Mail Order (60 do				
Tier 1	\$10 Copayment or 20%,	\$27 Consument			
1-34 day supply	greater of	\$27 Copayment			
Tier 1	\$27 Canayment				
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			
Her 3	greater of	\$110 Copayment			
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted					
Specialty Netwo	rk pharmacy. Limited to a 30 da	ay 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 medication	ions.
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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.

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



Aulternative 1500/100 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network

\$1,500 \$3,000	\$3,000 \$6,000
	· ·
	· ·
\$3,000	\$6,000
	70,000
\$1,500	\$6,000
\$3,000	\$12,000
	80% UCR
\$25 Copayment	\$25 Copayment UCR
Saa Ravarsa sida	1
Jee Nevelse side	<u> </u>
100%	50% UCR
100%	30% UCK
1000/	000/ 1100
100%	80% UCR
100%	80% UCR
20070	1 2370 3311
\$150 Copayment	\$150 Copayment UCR
. 1.7	, , , , , , , , , , , , , , , , , , , ,
\$50 Copayment	\$50 Copayment UCR
100%	80% UCR
100/0	00/0 OCK
4000′	1 000/1105
100%	80% UCR
100%	80% UCR
	1
100%	100% UCR
UNLIMITED	UNLIMITED
	\$3,000 Sine \$25 Copayment \$25 Copayment See Reverse side 100% 100% \$150 Copayment \$50 Copayment 100% 100%

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

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

Embedded Deductible. Each family member only needs to meet his/her individual deductible prior to receiving any benefits.

Appropriate Deductible or Copayment must be satisfied before any benefit is paid except as noted.

Deductible Carryover. Amounts applied to the Deductible in the last three months of the calendar year will be carried over to the next calendar year.

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



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 required. Medications must be obtained 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%,			
THE T	greater of	greater of			
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,			
TIEL 3	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 availability

4				10
Tier 1	is defined as I	Preterred	(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



Aulternative 2000/80 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	=
Calendar Year Deductible			Deductible and Out-of-Pocket
	\$2,000	\$4,000	Maximum are Non-Integrated.
Employee	\$4,000	\$8,000	Therefore, Deductible and Out-of-
Family	\$4,000	\$8,000	Pocket amounts met for Network Providers DO NOT apply to
Out-of-Pocket Maximum			Deductible and Out-of-Pocket
Employee	\$4,000	\$8,000	amounts met for Non-Network Providers.
Family	\$8,000	\$16,000	Froviders.
Tulliny	70,000	710,000	Embedded Deductible. Each
Physician Office Visits and Telemed	icine		family member only needs to meet his/her individual deductible prior
For Illness	\$25 Copayment	60% UCR	to receiving any benefits.
For Injury	\$25 Copayment	\$25 Copayment UCR	
For injury	723 Copayment	323 copayment och	Appropriate Deductible or
Prescription Drugs	See Reverse side	1	Copayment must be satisfied before any benefit is paid except
Prescription Drugs	see keverse 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%	50% 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
·			Preventive Health Services.
Emergency Services	\$50 Copayment	\$50 Copayment UCR	Pre-Approval is recommended for
		· · · · · ·	all Inpatient admissions.
Urgent Care	\$25 Copayment	\$25 Copayment UCR	Not all bone fit decoriations
	· ·	•	Not all benefit descriptions, exclusions and limitations are
Diagnostic Services			included in this document.
(Labs, X-rays)	80%	60% UCR	Complete benefit descriptions and
			exclusions are contained in the AultCare Insurance Company
Outpatient Therapy Services	80%	60% UCR	Certificates of Coverage and
,		1 2272 2277	Benefit Chart.
Other Services Refer to Summary			Contact AultCare
Plan Description	80%	60% UCR	www.aultcare.com
,		'	330-363-6360
Ambulance	80%	80% UCR	1-800-344-8858
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	327 Copayment	
Tier 1	\$27 Copayment		
35-60 day supply	327 Copayment		
Tier 2	\$20 Copayment or 30%,	\$55 Copayment	
HEI Z	greater of	333 copayment	
Tier 3	\$45 Copayment or 50%,	\$110 Copayment	
Hel 3	greater of	3110 Copayment	
Tier 4 and 5 - Prior Authorization is require	ed. Medications must be obtain	ed through an AultCare contracted	
Specialty Networ	k 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%,	
Her 5	greater of	greater of	
A thirty four (34) day supply is available at the retail pharmacy			
A sixty (60) day suppl	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 availability

Tier 1	is defined as Preferred Generic medications.
Her I	is defined as Freierred defield inedications.

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.

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



Aulternative 2000/100 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	=
Calendar Year Deductible			Deductible and Out-of-Pocket
Employee	\$2,000	\$4,000	Maximum are Non-Integrated.
Family	\$4,000	\$8,000	Therefore, Deductible and Out-of- Pocket amounts met for Network
Tulliny	γ-1,000	γο,οοο	Providers DO NOT apply to
Out-of-Pocket Maximum			Deductible and Out-of-Pocket amounts met for Non-Network
Employee	\$2,000	\$8,000	Providers.
Family	\$4,000	\$16,000	
· 1			Embedded Deductible. Each
Physician Office Visits and Telemedi	cine		family member only needs to meet his/her individual deductible prior
For Illness	\$25 Copayment	80% UCR	to receiving any benefits.
For Injury	\$25 Copayment	\$25 Copayment UCR	-
. o. mjary	7-0 00 00 1110110	1	Appropriate Deductible or Copayment must be satisfied
Prescription Drugs	See Reverse side	T	before any benefit is paid except
Frescription Drugs	See Neverse side		as noted.
Preventive Health Services			Deductible Carryover. Amounts
As defined by		T	applied to the Deductible in the
the Affordable Care Act.			last three months of the calendar
See www.healthcare.gov for	100%	50% UCR	year will be carried over to the
additional information.			next calendar year.
,		-	The Out-of-Pocket Maximum
Maternity Care	100%	80% UCR	amount includes the Deductible
,			and Medical Coinsurance.
Inpatient Hospital Services	100%	80% UCR	Deductible is waived for Network
			Preventive Health Services.
Emergency Services	\$50 Copayment	\$50 Copayment UCR	Pre-Approval is recommended for
		<u></u>	all Inpatient admissions.
Urgent Care	\$25 Copayment	\$25 Copayment UCR	Not all benefit descriptions,
			exclusions and limitations are
Diagnostic Services	100%	80% UCR	included in this document. Complete benefit descriptions and
(Labs, X-rays)		337.331.	exclusions are contained in the
			AultCare Insurance Company
Outpatient Therapy Services	100%	80% UCR	Certificates of Coverage and Benefit Chart.
Other Services Refer to Surger and		1	7
Other Services Refer to Summary	100%	80% UCR	Contact AultCare www.aultcare.com
Plan Description		1	330-363-6360
Ambulanca	1000/	100% LICE	1-800-344-8858
Ambulance	100%	100% UCR	
Annual Plan Maximum	UNLIMITED	UNLIMITED	
/ I I I I I I I I I I I I I I I I I I I	ONLIMITED	OMENALIED	



Prescription Drugs	Retail	Mail Order (60 day supply)	
Tier 1	\$10 Copayment or 20%, \$27 Copayment		
1-34 day supply	greater of	327 Copayment	
Tier 1	\$27 Copayment		
35-60 day supply	327 Copayment		
Tier 2	\$20 Copayment or 30%,	\$55 Copayment	
HEI Z	greater of	333 Copayment	
Tier 3	\$45 Copayment or 50%,	\$110 Copayment	
Hel 3	greater of	3110 Copayment	
Tier 4 and 5 - Prior Authorization is require	ed. Medications must be obtain	ed through an AultCare contracted	
Specialty Networ	k 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%,	
Her 5	greater of	greater of	
A thirty four (34) day supply is available at the retail pharmacy			
A sixty (60) day suppl	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 availability

Tier 1	is defined	as Preferred	Generic m	edications

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

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

Tier 4 is defined as Specialty Generic medications.

is defined as Specialty Brand medications. Tier 5

Diabetic Program

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

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



Aulternative 2500 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	=
Calendar Year Deductible			Deductible and Out-of-Pocket
Employee	\$2,500	\$4,000	Maximum are Non-Integrated.
Family	\$5,000	\$8,000	Therefore, Deductible and Out-of- Pocket amounts met for Network
Tulliny	ψ3,000	ψο,οσο	Providers DO NOT apply to
Out-of-Pocket Maximum			Deductible and Out-of-Pocket amounts met for Non-Network
Employee	\$2,500	\$8,000	Providers.
Family	\$5,000	\$16,000	
·		•	Embedded Deductible. Each family member only needs to meet
Physician Office Visits and Telemedi	icine		his/her individual deductible prior
For Illness	\$25 Copayment	80% UCR	to receiving any benefits.
For Injury	\$25 Copayment	\$25 Copayment UCR	Appropriate Deductible or
3 / 1	. , ,	, ,	Copayment must be satisfied
Prescription Drugs	See Reverse side		before any benefit is paid except
- Company of the Comp		I .	as noted.
Preventive Health Services			Deductible Carryover. Amounts
As defined by			applied to the Deductible in the
the Affordable Care Act.	100%	500/ LICD	last three months of the calendar
See www.healthcare.gov for	100%	50% UCR	year will be carried over to the next calendar year.
additional information.			next calcinaar year.
			The Out-of-Pocket Maximum
Maternity Care	100%	80% UCR	amount includes the Deductible
•			and Medical Coinsurance.
Inpatient Hospital Services	100%	80% UCR	Deductible is waived for Network
· · · · · · · · · · · · · · · · · · ·		•	Preventive Health Services.
Emergency Services	\$50 Copayment	\$50 Copayment UCR	Pre-Approval is recommended for
		+ , ,	all Inpatient admissions.
Urgent Care	\$25 Copayment	\$25 Copayment UCR	Nat all basefit descriptions
	· ·		Not all benefit descriptions, exclusions and limitations are
Diagnostic Services			included in this document.
(Labs, X-rays)	100%	80% UCR	Complete benefit descriptions and
1			exclusions are contained in the AultCare Insurance Company
Outpatient Therapy Services	100%	80% UCR	Certificates of Coverage and
	20070	1 20/3 3311	Benefit Chart.
Other Services Refer to Summary	10051	00011100	Contact AultCare
Plan Description	100%	80% UCR	www.aultcare.com
		•	330-363-6360
Ambulance	100%	100% UCR	1-800-344-8858
		1 2272 2 213	
Annual Plan Maximum	UNLIMITED	UNLIMITED	
		1 3	_



Prescription Drugs	Retail	Mail Order (60 day supply)	
Tier 1	\$10 Copayment or 20%,	\$27 Copayment	
1-34 day supply	greater of	327 Copayment	
Tier 1	¢27 Consument		
35-60 day supply	\$27 Copayment		
Tier 2	\$20 Copayment or 30%,	\$55 Copayment	
Tier 2	greater of	333 Copayment	
Tier 3	\$45 Copayment or 50%,	\$110 Copayment	
Tier 5	greater of	3110 Copayment	
Tier 4 and 5 - Prior Authorization is require	d. Medications must be obtain	ed through an AultCare contracted	
Specialty Networ	k pharmacy. Limited to a 30 da	y supply.	
Tier 4	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
1161 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 availability

Tier 1	is defined	as Preferred	Generic medications.	
HELT	is aciliea	as eletered	delielic illedications.	

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

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

Tier 4 is defined as Specialty Generic medications.

is defined as Specialty Brand medications. Tier 5

Diabetic Program

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

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



Aulternative 5000 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	=
Calendar Year Deductible			Deductible and Out-of-Pocket
	¢r 000	¢7.500	Maximum are Non-Integrated.
Employee	\$5,000	\$7,500	Therefore, Deductible and Out-of-
Family	\$10,000	\$15,000	Pocket amounts met for Network
r			Providers <u>DO NOT</u> apply to Deductible and Out-of-Pocket
Out-of-Pocket Maximum			amounts met for Non-Network
Employee	\$5,000	\$10,000	Providers.
Family	\$10,000	\$20,000	
		-	Embedded Deductible. Each family member only needs to meet
Physician Office Visits and Telemed	icine		his/her individual deductible prior
For Illness	\$25 Copayment	80% UCR	to receiving any benefits.
For Injury	\$25 Copayment	\$25 Copayment UCR	-
r or mary	φ25 copayment	y 23 copayment o cit	Appropriate Deductible or Copayment must be satisfied
Prescription Drugs	See Reverse side		before any benefit is paid except
Prescription Drugs	See Reverse side		as noted.
December 11 and 11 Construction			_
Preventive Health Services			Deductible Carryover. Amounts
As defined by			applied to the Deductible in the last three months of the calendar
the Affordable Care Act.	100%	50% UCR	year will be carried over to the
See www.healthcare.gov for			next calendar year.
additional information.			<u> </u>
			The Out-of-Pocket Maximum amount includes the Deductible
Maternity Care	100%	80% UCR	and Medical Coinsurance.
			<u> </u>
Inpatient Hospital Services	100%	80% UCR	Deductible is waived for Network
<u> </u>		-	Preventive Health Services.
Emergency Services	\$50 Copayment	\$50 Copayment UCR	Pre-Approval is recommended for
	• •		all Inpatient admissions.
Urgent Care	\$25 Copayment	\$25 Copayment UCR	
- Ben 2011	7-2 35 pay	φ25 σσραγιιτοίτε σ στι	Not all benefit descriptions, exclusions and limitations are
Diagnostic Comices			included in this document.
Diagnostic Services	100%	80% UCR	Complete benefit descriptions and
(Labs, X-rays)			exclusions are contained in the
			AultCare Insurance Company
Outpatient Therapy Services	100%	80% UCR	Certificates of Coverage and Benefit Chart.
Other Services Refer to Summary	100%	900/ LICD	Contact AultCare
Plan Description	100%	80% UCR	www.aultcare.com
			330-363-6360
Ambulance	100%	100% UCR	1-800-344-8858
- 2000			_
Annual Plan Maximum	UNLIMITED	UNLIMITED	┐
,	3.42	J. G.	_



Prescription Drugs	Retail	Mail Order (60 day supply)	
Tier 1	\$10 Copayment or 20%, \$27 Copayment		
1-34 day supply	greater of	327 Copayment	
Tier 1	\$27 Copayment		
35-60 day supply	327 Copayment		
Tier 2	\$20 Copayment or 30%,	\$55 Copayment	
HEI Z	greater of	333 copayment	
Tier 3	\$45 Copayment or 50%,	\$110 Copayment	
Hel 3	greater of	3110 Copayment	
Tier 4 and 5 - Prior Authorization is require	ed. Medications must be obtain	ed through an AultCare contracted	
Specialty Networ	k 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%,	
Her 5	greater of	greater of	
A thirty four (34) day supply is available at the retail pharmacy			
A sixty (60) day suppl	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 availability

Tier 1	is defined as Preferred Generic medications.
Her I	is defined as Freierred defield inedications.

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.

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



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

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$2,000	\$4,000
Family	\$4,000	\$8,000
Out-of-Pocket Maximum		
Employee	\$2,000	\$8,000
Family	\$4,000	\$16,000
Physician Office Visits and Telemedic	ine	
For Illness	100%	80% UCR
For Injury	100%	100% UCR
Prescription Drugs (Follow Premium Managed Formulary)	100%	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% UCR
See www.healthcare.gov for	100/0	30% UCK
additional information.		
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	80% UCR
Diagnostic Services (Labs, X-rays)	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services (Refer to Summary Plan Description)	100%	80% UCR
Ambulance	100%	100% UCR
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



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

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$2,500	\$4,000
Family	\$5,000	\$8,000
Out-of-Pocket Maximum		
Employee	\$2,500	\$8,000
Family	\$5,000	\$16,000
Physician Office Visits and Telemedic	ine	
For Illness	100%	80% UCR
For Injury	100%	100% UCR
Prescription Drugs (Follow Premium Managed Formulary)	100%	
Preventive Health Services		
As defined by	100%	50% UCR
the Affordable Care Act.		
See www.healthcare.gov for		
additional information.		
Maternity Care	100%	80% UCR
Inpatient Hospital Services	100%	80% UCR
Emergency Services	100%	100% UCR
Urgent Care	100%	100% UCR
Diagnostic Services (Labs, X-rays)	100%	80% UCR
Outpatient Therapy Services	100%	80% UCR
Other Services (Refer to Summary Plan Description)	100%	80% UCR
Ambulance	100%	100% UCR
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