

#### Gold 850

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

Network	Non-Network	
\$850	\$2,550	
\$1,700	\$5,100	
¢E 600	\$26,100	
	\$52,200	
\$11,200	<del>332,200</del>	
\$25 Copayment	50% RBP	
\$25 Copayment	50% RBP	
\$45 Copayment	50% RBP	
,		
See Reverse side		
100%	50% RBP	
70%	50% RBP	
70%	50% RBP	
70%	70% RBP	
\$75 Copayment	\$75 Copayment RBP	
70%	50% RBP	
70%	50% RBP	
1		
70%	50% RBP	
70%	70% RBP	
	\$850 \$1,700 \$5,600 \$11,200 \$25 Copayment \$25 Copayment \$45 Copayment \$46 Copayment \$100% 70% 70% 70% \$75 Copayment	

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 member of a family is looked upon as an individual in regard to the Deductible. Once a member reaches the single Deductible, Coinsurance will apply.

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

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

Deductible is waived for Network Preventive Health Services.

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

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

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

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



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

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

Tier 1	is defined as	s Preventive	Maintenance	medications.
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**Tier 2** is defined as Preferred Generic medications.

Tier 3 is defined as Non-Preferred Generic and Preferred Brand medications.Tier 4 is defined as Non-Preferred Generic & Non-Preferred Brand medications.

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

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

<sup>\*</sup> A 60-day supply of Tier 2 Prescription drugs may be obtained at the Retail Pharmacy for the Mail Order amount.



#### Gold 1050

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

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$1,050	\$3,150
Family	\$2,100	\$6,300
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Out-of-Pocket Maximum		
Employee	\$6,700	\$26,100
Family	\$13,400	\$52,200
Physician Office Visits	¢20 Comprised	CON/ DDD
Illness/Injury	\$20 Copayment	60% RBP
Telemedicine	\$20 Copayment	60% RBP
Specialist Office Visits		
Illness/Injury	\$40 Copayment	60% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	60% RBP
See www.healthcare.gov for		20/1.112
additional information.		
Mataunitus Cava	900/	COO/ DDD
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
patient nespital del tides	30,0	00/01/2/
Emergency Services	80%	80% RBP
,		
Urgent Care	\$75 Copayment	\$75 Copayment RBP
Diagnostic Services	80%	60% RBP
(Labs, X-rays)		
Outpatient Therapy Services	80%	60% RBP
Outpatient merapy services	OU/0	0070 NBP
Other Services (Refer to	2001	6067
Summary Plan Description)	80%	60% RBP
Ambulance	80%	80% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED

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

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

Embedded Deductible. Each member of a family is looked upon as an individual in regard to the Deductible. Once a member reaches the single Deductible, Coinsurance will apply.

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

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

Deductible is waived for Network Preventive Health Services.

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

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

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

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

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

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

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

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

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

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

<sup>\*</sup> A 60-day supply of Tier 2 Prescription drugs may be obtained at the Retail Pharmacy for the Mail Order amount.



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

Medical Benefits	Network	Non-Network	Deductible and •  Maximum are N
			Therefore, Dedu
Calendar Year Deductible			Pocket amounts
Employee	\$1,650	\$4,950	Providers <b>DO NO</b>
Family	\$3,300	\$9,900	Deductible and ( amounts met for
Out-of-Pocket Maximum			Providers.
Employee	\$6,700	\$26,100	Embedded Ded
Family	\$13,400	\$52,200	member of a far
•			as an individual
Physician Office Visits			Deductible. Onc
Illness/Injury	\$20 Copayment	70% RBP	the single Dedu will apply.
Telemedicine	\$20 Copayment	70% RBP	will apply.
			Appropriate De
Specialist Office Visits			satisfied before
Illness/Injury	\$40 Copayment	70% RBP	except as noted
Duna suintian Duna	Con Doverso side		The Out-of-Pock
Prescription Drugs	See Reverse side		amount includes Copayments and
Preventive Health Services			
As defined by			Deductible is w
the Affordable Care Act.			Preventive Hea
See www.healthcare.gov for	100%	70% RBP	Pediatric Dental
additional information.			age 19) are inclu
additional information			Refer to certifica
Maternity Care	90%	70% RBP	details.
•			Note: If you hav
Inpatient Hospital Services	90%	70% RBP	<b>certified</b> standa
-			provided an atte
Emergency Services	90%	90% RBP	regarding that p pediatric dental
Humant Cara	¢75 Comprise and	Ć75 Consument DDD	check-up, will be
Urgent Care	\$75 Copayment	\$75 Copayment RBP	that dental plan
Diagnostic Services	0001	700/ 555	Not all benefit d
(Labs, X-rays)	90%	70% RBP	exclusions and l
			benefit descripti
Outpatient Therapy Services	90%	70% RBP	are contained in
			Insurance Comp
Other Services (Refer to	90%	70% RBP	Coverage and Be
Summary Plan Description)	J0/0	7 0 /0 I\DF	Contact AultCar
			www.aultcare.c
Ambulance	90%	90% RBP	330-363-6360 1-800-344-8858
Annual Plan Maximum	UNLIMITED	UNLIMITED	
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ctible. Each ily is looked upon regard to the a member reaches ible, Coinsurance

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t Maximum the Deductible, Coinsurance.

ved for Network h Services.

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

purchased a ne dental plan and tation to AultCare an, coverage for ncluding a dental provided through

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



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

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

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

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

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

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

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

<sup>\*</sup> A 60-day supply of Tier 2 Prescription drugs may be obtained at the Retail Pharmacy for the Mail Order amount.



#### Gold 2500 HSA

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

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$2,500	\$7,500
Family	\$5,000	\$15,000
Out-of-Pocket Maximum		
Employee	\$2,500	\$26,100
Family	\$5,000	\$52,200
Physician Office Visits		
Illness/Injury	100%	80% RBP
Telemedicine	100%	80% RBP
Specialist Office Visits		
Illness/Injury	100%	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	80% RBP
See www.healthcare.gov for	100%	80% KBP
additional information.		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services (Labs, X-rays)	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to Summary Plan Description)	100%	80% RBP
Ambulance	100%	100% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED

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

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

**Unembedded Deductible.** Family Deductibles are per family, there is no per-person Deductible. Therefor, if you have family coverage, one or more persons must satisfy the family Deductible amount.

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

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

Deductible is waived for Network Preventive Health Services.

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

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

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

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



Prescription Drugs	Retail (34 Day Supply Unless Noted)	Mail Order (90 day supply)	
Tier 1 - 1-60 day supply/Retail	\$0 Copayment	\$0 Copayment	
Tier 2 - 1-60 day supply	100% Coinsurance	100% Coinsurance	
Tier 3	100% Coinsurance	100% Coinsurance	
Tier 4	100% Coinsurance	100% Coinsurance	
Tier 5 and 6 - Prior Authorization is required. Medications must be obtained through an AultCare contracted  Specialty Network pharmacy. Limited to a 30 day supply.			
Tier 5	100% Coinsurance	e N/A	
Tier 6	100% Coinsurance	N/A	

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

**Tier 1** is defined as Preventive Maintenance medications.

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

Tier 3 is defined as Non-Preferred Generic and Preferred Brand medications.Tier 4 is defined as Non-Preferred Generic & Non-Preferred Brand medications.

Tier 5 is defined as Preferred Generic Specialty medications.Tier 6 is defined as Preferred Brand Specialty medications.



## **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network	Deductible and Out  Maximum are Non-
			Therefore, Deductik
Calendar Year Deductible	40.000	40.700	Pocket amounts me
Employee	\$2,900	\$8,700	Providers <b>DO NOT</b> a
Family	\$5,800	\$17,400	Deductible and Out amounts met for No
Out-of-Pocket Maximum			Providers.
Employee	\$4,200	\$26,100	Embedded Deducti
Family	\$8,400	\$52,200	member of a family
			as an individual in re  Deductible. Once a
Physician Office Visits	4.00		the single Deductible
Illness/Injury	\$10 Copayment	70% RBP	will apply.
Telemedicine	\$10 Copayment	70% RBP	
Constitution Office Winite			Appropriate Deduction satisfied before any
Specialist Office Visits	¢20 Canavarant	700/ DDD	except as noted.
Illness/Injury	\$30 Copayment	70% RBP	
Duna animtia na Duna na	Coo Doverso side		The Out-of-Pocket N
Prescription Drugs	See Reverse side		amount includes the Copayments and Co
Preventive Health Services			
As defined by			Deductible is waive
the Affordable Care Act.	1000/	700/ 777	Preventive Health S
See www.healthcare.gov for	100%	70% RBP	Pediatric Dental and
additional information.			age 19) are included
,			Refer to certificate f
Maternity Care	90%	70% RBP	details.
			Note: If you have pu
Inpatient Hospital Services	90%	70% RBP	certified standalone provided an attestal
[	000/	000/ 000	regarding that plan,
Emergency Services	90%	90% RBP	pediatric dental, inc
Ungent Core	¢7F Canaumant	Ć7F Congument DDD	check-up, will be pro
Urgent Care	\$75 Copayment	\$75 Copayment RBP	that dental plan.
Diagnostic Services	222/		Not all benefit descr
(Labs, X-rays)	90%	70% RBP	exclusions and limit included in this docu
			benefit descriptions
Outpatient Therapy Services	90%	70% RBP	are contained in the
			Insurance Company
Other Services (Refer to	00%	70% RBP	Coverage and Benef
Summary Plan Description)	90%	/U% KBP	Contact AultCare
			www.aultcare.com
Ambulance	90%	90% RBP	330-363-6360 1-800-344-8858
Annual Plan Maximum	UNLIMITED	UNLIMITED	1-000-344-0036
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Maximum he Deductible, coinsurance.

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nd Vision (up to ed in this plan. for full benefit

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criptions, itations are cument. Complete ns and exclusions ne AultCare y Certificates of efit Chart.



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

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

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

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

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

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

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

<sup>\*</sup> A 60-day supply of Tier 2 Prescription drugs may be obtained at the Retail Pharmacy for the Mail Order amount.