Silver 2000
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,000	$6,000
Family	$4,000	$12,000
Out-of-Pocket Maximum		
Employee	$8,700	$26,100
Family	$17,400	$52,200
Physician Office Visits		
Illness/Injury	$45 Copayment	40% RBP
Telemedicine	$45 Copayment	40% RBP
Specialist Office Visits		
Illness/Injury	$65 Copayment	40% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	40% RBP
Maternity Care	50%	40% RBP
Inpatient Hospital Services	50%	40% RBP
Emergency Services	50%	50% RBP
Urgent Care	$75 Copayment	$75 Copayment RBP
Diagnostic Services	50%	40% RBP
Outpatient Therapy Services	50%	40% RBP
Other Services *(Refer to*	50%	40% RBP
Ambulance	50%	50% 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.

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

This information is intended to provide a summary of products offered by AultCare.

Prescription Drugs	**Retail** (34 Day Supply Unless Noted)	**Mail Order** (*90 day supply)*
Tier 1 - 1-60 day supply/Retail	$0 Copayment	$0 Copayment
*Tier 2 - 1-34 day supply**	$10 Copayment or 20%, greater of	$30 Copayment or 20%, greater of
Tier 3	$20 Copayment or 30%, greater of	$55 Copayment or 25%, greater of
Tier 4	$45 Copayment or 40%, greater of	$125 Copayment or 35%, greater of
Tier 5 and 6 - Prior Authorization is 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

Tier Definitions

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

Tier 1 is defined as Preventive Maintenance medications.
Tier 2 is defined as Preferred Generic medications.
Tier 3 is defined as Non-Preferred Generic and Preferred Brand medications.
Tier 4 is defined as Non-Preferred Generic & Non-Preferred Brand medications.
Tier 5 is defined as Preferred Generic Specialty medications.
Tier 6 is defined as Preferred Brand Specialty medications.

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

This information is intended to provide a summary of products offered by AultCare.

Silver 2400 HSA
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$2,400	$7,200
Family	$4,800	$14,400
Out-of-Pocket Maximum		
Employee	$7,000	$26,100
Family	$14,000	$52,200
Physician Office Visits		
Illness/Injury	80%	60% RBP
Telemedicine	80%	60% RBP
Specialist Office Visits		
Illness/Injury	80%	60% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	60% RBP
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	80%	80% RBP
Urgent Care	80%	80% RBP
Diagnostic Services	80%	60% RBP
Outpatient Therapy Services	80%	60% RBP
Other Services *(Refer to*	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.

Unembedded Deductible. Family Deductibles are per family; there is no per-person Deductible. Therefore, 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

This information is intended to provide a summary of products offered by AultCare.

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

Tier Definitions

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

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.

This information is intended to provide a summary of products offered by AultCare.

AULTCARE

Silver 3550

Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$3,550	$10,650
Family	$7,100	$21,300
Out-of-Pocket Maximum		
Employee	$8,700	$26,100
Family	$17,400	$52,200
Physician Office Visits		
Illness/Injury	$40 Copayment	50% RBP
Telemedicine	$40 Copayment	50% RBP
Specialist Office Visits		
Illness/Injury	$60 Copayment	50% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	70%	50% RBP
Inpatient Hospital Services	70%	50% RBP
Emergency Services	70%	70% RBP
Urgent Care	$75 Copayment	$75 Copayment RBP
Diagnostic Services *(Labs, X-rays)*	70%	50% RBP
Outpatient Therapy Services	70%	50% RBP
Other Services *(Refer to Summary Plan Description)*	70%	50% RBP
Ambulance	70%	70% 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.

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

This information is intended to provide a summary of products offered by AultCare.

Prescription Drugs	**Retail** (34 Day Supply Unless Noted)	**Mail Order** (*90 day supply)*
Tier 1 - 1-60 day supply/Retail	$0 Copayment	$0 Copayment
*Tier 2 - 1-34 day supply**	$10 Copayment or 20%, greater of	$30 Copayment or 20%, greater of
Tier 3	$20 Copayment or 30%, greater of	$55 Copayment or 25%, greater of
Tier 4	$45 Copayment or 40%, greater of	$125 Copayment or 35%, greater of
Tier 5 and 6 - Prior Authorization is 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

Tier Definitions

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

Tier 1 is defined as Preventive Maintenance medications.
Tier 2 is defined as Preferred Generic medications.
Tier 3 is defined as Non-Preferred Generic and Preferred Brand medications.
Tier 4 is defined as Non-Preferred Generic & Non-Preferred Brand medications.
Tier 5 is defined as Preferred Generic Specialty medications.
Tier 6 is defined as Preferred Brand Specialty medications.

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

This information is intended to provide a summary of products offered by AultCare.

Silver 4250 HSA
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$4,250	$12,750
Family	$8,500	$25,500
Out-of-Pocket Maximum		
Employee	$4,250	$26,100
Family	$8,500	$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. See www.healthcare.gov for additional information.	100%	80% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services	100%	80% RBP
Outpatient Therapy Services	100%	80% RBP
Other Services *(Refer to*	100%	80% RBP
Ambulance	100%	100% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED

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

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

This information is intended to provide a summary of products offered by AultCare.

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

Tier Definitions

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

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.

This information is intended to provide a summary of products offered by AultCare.

Silver 5400
Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	$5,400	$16,200
Family	$10,800	$32,400
Out-of-Pocket Maximum		
Employee	$8,700	$26,100
Family	$17,400	$52,200
Physician Office Visits		
Illness/Injury	$25 Copayment	65% RBP
Telemedicine	$25 Copayment	65% RBP
Specialist Office Visits		
Illness/Injury	$45 Copayment	65% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	65% RBP
Maternity Care	85%	65% RBP
Inpatient Hospital Services	85%	65% RBP
Emergency Services	85%	85% RBP
Urgent Care	$75 Copayment	$75 Copayment RBP
Diagnostic Services	85%	65% RBP
Outpatient Therapy Services	85%	65% RBP
Other Services *(Refer to*	85%	65% RBP
Ambulance	85%	85% 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.

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1-800-344-8858

This information is intended to provide a summary of products offered by AultCare.

Prescription Drugs	**Retail** (34 Day Supply Unless Noted)	**Mail Order** (*90 day supply)*
Tier 1 - 1-60 day supply/Retail	$0 Copayment	$0 Copayment
*Tier 2 - 1-34 day supply**	$10 Copayment or 20%, greater of	$30 Copayment or 20%, greater of
Tier 3	$20 Copayment or 30%, greater of	$55 Copayment or 25%, greater of
Tier 4	$45 Copayment or 40%, greater of	$125 Copayment or 35%, greater of
Tier 5 and 6 - Prior Authorization is 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

Tier Definitions

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

Tier 1 is defined as Preventive Maintenance medications.
Tier 2 is defined as Preferred Generic medications.
Tier 3 is defined as Non-Preferred Generic and Preferred Brand medications.
Tier 4 is defined as Non-Preferred Generic & Non-Preferred Brand medications.
Tier 5 is defined as Preferred Generic Specialty medications.
Tier 6 is defined as Preferred Brand Specialty medications.

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

This information is intended to provide a summary of products offered by AultCare.