AULTCARE

STANDARD HIGH OPTION 90%, GPP I, GPP III, 80% Option II, $750 Plan

SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS	High Option 90%		Group Purchasing Plan I		Group Purchasing Plan III		80% Option II		$750 Plan	
	Network	Non Network	Network	Non Network	Network	Non Network	Network	Non Network	Network	Non Network
Calendar Year Deductible										
Employee	$150	$450	$100	$300	$200	$600	$300	$900	$750	$2,250
Family	$300	$900	$300	$900	$400	$1,200	$600	$1,800	$1,500	$4,500
Benefit Level	90%*	80%*RBP	90%*	65%*RBP	90%*	70%*RBP	80%*	60%*RBP	80%*	60%*RBP
Medical Out-of-Pocket Maximum										
Employee	$500	$1,500	$600	$1,800	$700	$2,100	$1,300	$3,900	$3,000	$9,000
Family	$1,000	$3,000	$1,500	$4,500	$1,400	$4,200	$2,600	$7,800	$6,000	$18,000
Prescription Drug Out-of-Pocket Maximum (Separate from Medical)										
Employee	$8,050	N/A	$7,950	N/A	$7,850	N/A	$7,250	N/A	$5,550	N/A
Family	$16,100	N/A	$15,600	N/A	$15,700	N/A	$14,500	N/A	$11,100	N/A
Annual Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Emergency Services	$75 Copayment	$75 Copayment RBP	$75 Copayment	$75 Copayment RBP	$75 Copayment	$75 Copayment RBP	$75 Copayment	$75 Copayment RBP	$75 Copayment	$75 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP
Preventive Health Services As defined by the Affordable Care Act.	100%	80%*RBP	100%	65%*RBP	100%	70%*RBP	100%	60%*RBP	100%	60%*RBP
Maternity Care	90%*	80%*RBP	90%*	65%*RBP	90%*	70%*RBP	80%*	60%*RBP	80%*	60%*RBP
Inpatient Hospital Services	90%*	80%*RBP	90%*	65%*RBP	90%*	70%*RBP	80%*	60%*RBP	80%*	60%*RBP
Diagnostic Services (Labs, X-rays)	90%*	80%*RBP	90%*	65%*RBP	90%*	70%*RBP	80%*	60%*RBP	80%*	60%*RBP
Outpatient Therapy Services	90%*	80%*RBP	90%*	65%*RBP	90%*	70%*RBP	80%*	60%*RBP	80%*	60%*RBP
Second Surgical Opinion	90%*	80%*RBP	90%*	65%*RBP	90%*	70%*RBP	80%*	60%*RBP	80%*	60%*RBP
Other Services (Refer to plan benefit chart)	90%*	80%*RBP	90%*	65%*RBP	90%*	70%*RBP	80%*	60%*RBP	80%*	60%*RBP
Ambulance	80%*	80%*RBP	80%*	80%*RBP	80%*	80%*RBP	80%*	80%*RBP	80%*	80%*RBP
Physician Office Visits										
Visits for Illness / Injury	90%*	80%*RBP	$10 Copayment $5 Copayment OB/GYN	65%*RBP	$10 Copayment	70%*RBP	80%*	60%*RBP	$25 Copayment	60%*RBP
Telemedicine	90%*	80%*RBP	$10 Copayment	65%*RBP	$10 Copayment	70%*RBP	80%*	60%*RBP	$25 Copayment	60%*RBP

Prescription Drugs

Retail		Mail Order (90 day supply)	
Preferred Generic (1-34 days) - **Tier 1**	$10 Copayment or 20%, greater of	Preferred Generic - **Tier 1**	$25 Copayment or 20%, greater of
Preferred Generic (35-60 days) - **Tier 1**	$20 Copayment or 20%, greater of		
Preferred Brand & Non-Preferred Generic - **Tier 2**	$30 Copayment or 30%, greater of	Preferred Brand & Non-Preferred Generic - **Tier 2**	$85 Copayment or 25%, greater of ($200 max)
Non-Preferred Brand & Non-Preferred Generic - **Tier 3**	$45 Copayment or 50%, greater of	Non-Preferred Brand & Non-Preferred Generic - **Tier 3**	$130 Copayment or 45%, greater of ($400 max)

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.

Specialty Generic - **Tier 4**	$10 Copayment or 20%, greater of	Specialty Generic - **Tier 4**	$10 Copayment or 20%, greater of
Specialty Brand - **Tier 5**	$125 Copayment or 20%, greater of	Specialty Brand - **Tier 5**	$125 Copayment or 20%, greater of

*** After Deductible**

RBP stands for Reference Based Pricing

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. 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.

Medical plan Copayments apply to the Medical Out-of-Pocket and Prescription drug Copayments apply to the Pescription drug Out-of-Pocket.

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AULTCARE

2021

AULTERNATIVE PLANS SCHEDULE A 1500 Plans
HEALTH SAVINGS ACCOUNT (HSA) COMPATIBLE
SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS	Aulternative A 1500/80 Network	Aulternative A 1500/80 Non Network	Aulternative A 1500/100 Network	Aulternative A 1500/100 Non Network
Calendar Year Deductible				
Employee	$1,500	$4,500	$1,500	$4,500
Family	$3,000	$9,000	$3,000	$9,000
Benefit Level	80%*	60%*RBP	100%*	80%*RBP
Medical Out-of-Pocket Maximum				
Employee	$4,150	$12,450	$1,500	$9,000
Family	$6,650	$19,950	$3,000	$18,000
Annual Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Emergency Services	100%*	100%*RBP	100%*	100%*RBP
Urgent Care	80%*	80%*RBP	100%*	100%*RBP
Preventive Health Services As defined by the Affordable Care Act.	100%	50%*RBP	100%	50%*RBP
Maternity Care	80%*	60%*RBP	100%*	80%*RBP
Inpatient Hospital Services	80%*	60%*RBP	100%*	80%*RBP
Diagnostic Services (Labs, X-Rays)	80%*	60%*RBP	100%*	80%*RBP
Outpatient Therapy Services	80%*	60%*RBP	100%*	80%*RBP
Second Surgical Opinion	80%*	60%*RBP	100%*	80%*RBP
Other Services (Refer to plan benefit chart)	80%*	60%*RBP	100%*	80%*RBP
Ambulance	80%*	80%*RBP	100%*	100%*RBP
Physician Office Visits				
Visits for Illness / Injury	80%*	60%*RBP	100%*	80%*RBP
Telemedicine	80%*	60%*RBP	100%*	80%*RBP
Prescription Drugs	80%*		100%*	

*** After Deductible**

RBP stands for Reference Based Pricing

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.

Deductible and Out-of-Pocket maximums are non-integrated. Therefore, Deductibles and Out-of-Pocket amounts met for Network Providers DO NOT apply to Deductible and Out-of-Pocket amounts met for Non-Network providers.

These plans are constructed to be HSA compatible. Therefore, Deductible will be indexed to correspond to IRS guidelines.

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AULTCARE

AULTERNATIVE PLANS SCHEDULE A 2000, 2500 and 3000 Plans
HEALTH SAVINGS ACCOUNT (HSA) COMPATIBLE
SCHEDULE OF HEALTH INSURANCE BENEFITS

	Aulternative A 2000/80		Aulternative A 2000/100		Aulternative A 2500		Aulternative A 3000	
MEDICAL BENEFITS	**Network**	**Non Network**	**Network**	**Non Network**	**Network**	**Non Network**	**Network**	**Non Network**
Calendar Year Deductible								
Employee	$2,000	$6,000	$2,000	$6,000	$2,500	$7,500	$3,000	$9,000
Family	$4,000	$12,000	$4,000	$12,000	$5,000	$15,000	$6,000	$18,000
Benefit Level	80%*	60%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Medical Out-of-Pocket Maximum								
Employee	$4,150	$12,450	$2,000	$12,000	$2,500	$15,000	$3,000	$18,000
Family	$6,650	$19,950	$4,000	$24,000	$5,000	$30,000	$6,000	$36,000
Annual Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Emergency Services	80%*	80%*RBP	100%*	100% RBP	100%*	100%*RBP	100%*	100%*RBP
Urgent Care	80%*	80%*RBP	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP
Preventive Health Services As defined by the Affordable Care Act.	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP
Maternity Care	80%*	60%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Inpatient Hospital Services	80%*	60%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Diagnostic Services (Labs, X-Rays)	80%*	60%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Outpatient Therapy Services	80%*	60%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Second Surgical Opinion	80%*	60%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Other Services (Refer to plan benefit chart)	80%*	60%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Ambulance	80%*	80%*RBP	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP
Physician Office Visits			100%*					
Visits for Illness / Injury	80%*	60%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Telemedicine	80%*	60%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Prescription Drugs	80%*		100%*		100%*		100%*	

*** After Deductible**

RBP stands for Reference Based Pricing

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Deductible and Out-of-Pocket maximums are non-integrated. Therefore, Deductibles and Out-of-Pocket amounts met for Network Providers DO NOT apply to Deductible and Out-of-Pocket amounts met for Non-Network providers.

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AULTCARE

AULTERNATIVE PLANS SCHEDULE B 1000, 1500, 2000/80

SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS	Aulternative B 1000/80		Aulternative B 1000/100		Aulternative B 1500/80		Aulternative B 1500/100		Aulternative B 2000/80	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Calendar Year Deductible										
Employee	$1,000	$3,000	$1,000	$3,000	$1,500	$4,500	$1,500	$4,500	$2,000	$6,000
Family	$2,000	$6,000	$2,000	$6,000	$3,000	$9,000	$3,000	$9,000	$4,000	$12,000
Benefit Level	80%*	60%*RBP	100%*	80%*RBP	80%	80%*RBP	100%*	80%*RBP	80%*	60%*RBP
Medical Out-of-Pocket Maximum										
Employee	$2,000	$6,000	$1,000	$6,000	$2,500	$7,500	$1,500	$9,000	$4,000	$12,000
Family	$4,000	$12,000	$2,000	$12,000	$5,000	$15,000	$3,000	$18,000	$8,000	$24,000
Prescription Drug Out-of-Pocket Maximum (Separate from Medical)										
Employee	$6,550	N/A	$7,550	N/A	$6,050	N/A	$7,050	N/A	$4,550	N/A
Family	$13,100	N/A	$15,100	N/A	$12,100	N/A	$14,100	N/A	$9,100	N/A
Annual Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Emergency Services	$150 Copayment	$150 Copayment RBP	$150 Copayment	$150 Copayment RBP	$150 Copayment	$150 Copayment RBP	$150 Copayment	$150 Copayment RBP	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP
Preventive Health Services As defined by the Affordable Care Act.	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP
Maternity Care	80%*	60%*RBP	100%*	80%*RBP	80%	60%*RBP	100%*	80%*RBP	80%*	60%*RBP
Inpatient Hospital Services	80%*	60%*RBP	100%*	80%*RBP	80%	60%*RBP	100%*	80%*RBP	80%*	60%*RBP
Diagnostic Services (Labs, X-Rays)	80%*	60%*RBP	100%*	80%*RBP	80%	60%*RBP	100%*	80%*RBP	80%*	60%*RBP
Outpatient Therapy Services	80%*	60%*RBP	100%*	80%*RBP	80%	60%*RBP	100%*	80%*RBP	80%*	60%*RBP
Second Surgical Opinion	80%*	60%*RBP	100%*	80%*RBP	80%	60%*RBP	100%*	80%*RBP	80%*	60%*RBP
Other Services (Refer to plan benefit chart)	80%*	60%*RBP	100%*	80%*RBP	80%	60%*RBP	100%*	80%*RBP	80%*	60%*RBP
Ambulance	80%*	80%*RBP	100%*	100%*RBP	80%	80%*RBP	100%*	100%*RBP	80%*	80%*RBP
Physician Office Visits										
Visits for Illness / Injury	$25 Copayment	60%*RBP	$25 Copayment	80%*RBP	$25 Copayment	60%*RBP	$25 Copayment	80%*RBP	$25 Copayment	60%*RBP
Telemedicine	$25 Copayment	60%*RBP	$25 Copayment	80%*RBP	$25 Copayment	60%*RBP	$25 Copayment	80%*RBP	$25 Copayment	60%*RBP

Prescription Drugs

	Retail	Mail Order (90 day supply)	
Preferred Generic (1-34 days) - **Tier 1**	$10 Copayment or 20%, greater of	Preferred Generic - **Tier 1**	$25 Copayment or 20%, greater of
Preferred Generic (35-60 days) - **Tier 1**	$20 Copayment or 20%, greater of		
Preferred Brand & Non-Preferred Generic - **Tier 2**	$30 Copayment or 30%, greater of	Preferred Brand & Non-Preferred Generic - **Tier 2**	$85 Copayment or 25%, greater of ($200 max)
Non-Preferred Brand & Non-Preferred Generic - **Tier 3**	$45 Copayment or 50%, greater of	Non-Preferred Brand & Non-Preferred Generic - **Tier 3**	$130 Copayment or 45%, greater of ($400 max)

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.

Specialty Generic - **Tier 4**	$10 Copayment or 20%, greater of	Specialty Generic - **Tier 4**	$10 Copayment or 20%, greater of
Specialty Brand - **Tier 5**	$125 Copayment or 20%, greater of	Specialty Brand - **Tier 5**	$125 Copayment or 20%, greater of

***** **After Deductible**

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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. 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.

Medical plan Copayments apply to the Medical Out-of-Pocket and Prescription drug Copayments apply to the Pescription drug Out-of-Pocket.

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AULTCARE

AULTERNATIVE PLANS SCHEDULE B 2000-100, 2500, 5000, 7150 & Max Limit

SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS	Aulternative B 2000/100		Aulternative B 2500		Aulternative B 5000		Aulternative B 7150		Aultra Max Limit B	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Calendar Year Deductible										
Employee	$2,000	$6,000	$2,500	$7,500	$5,000	$15,000	$7,150	$21,450	$8,550	$22,650
Family	$4,000	$12,000	$5,000	$15,000	$10,000	$30,000	$14,300	$42,900	$17,100	$45,300
Benefit Level	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Medical Out-of-Pocket Maximum										
Employee	$2,000	$12,000	$2,500	$15,000	$8,550	$25,650	$8,550	$25,650	$8,550	$25,650
Family	$4,000	$24,000	$5,000	$30,000	$17,100	$51,300	$17,100	$51,300	$17,100	$51,300
Prescription Drug Out-of-Pocket Maximum (Separate from Medical)										
Employee	$6,550	N/A	$6,050	N/A	Pharmacy Out-of-Pocket integrated with Network Medical Out-of-Pocket		Pharmacy Out-of-Pocket integrated with Network Medical Out-of-Pocket		Pharmacy Out-of-Pocket integrated with Network Medical Out-of Pocket	
Family	$13,100	N/A	$12,100	N/A						
Annual Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Emergency Services	$150 Copayment	$150 Copayment RBP	$150 Copayment	$150 Copayment RBP	$150 Copayment	$150 Copayment RBP	$150 Copayment	$150 Copayment RBP	$150 Copayment	$150 Copayment RBP
Urgent Care	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP	$50 Copayment	$50 Copayment RBP
Preventive Health Services As defined by the Affordable Care Act.	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP
Maternity Care	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Inpatient Hospital Services	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Diagnostic Services (Labs, X-Rays)	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Outpatient Therapy Services	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Second Surgical Opinion	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Other Services (Refer to plan benefit chart)	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Ambulance	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP
Physician Office Visits										
Visits for Illness / Injury	$25 Copayment	80%*RBP	$25 Copayment	80%*RBP	$25 Copayment	80%*RBP	$25 Copayment	80%*RBP	$25 Copayment	80%*RBP
Telemedicine	$25 Copayment	80%*RBP	$25 Copayment	80%*RBP	$25 Copayment	80%*RBP	$25 Copayment	80%*RBP	$25 Copayment	80%*RBP

Prescription Drugs

	Retail	Mail Order (90 day supply)
(1-34 days) - **Tier 1**	$10 Copayment or 20%, greater of	
Preferred Generic (35-60 days) - **Tier 1**	$20 Copayment or 20%, greater of	Preferred Generic - **Tier 1** $25 Copayment or 20%, greater of
Preferred Brand & Non-Preferred Generic - **Tier 2**	$30 Copayment or 30%, greater of	Preferred Brand & Non-Preferred Generic - **Tier 2** $85 Copayment or 25%, greater of ($200 max)
Non-Preferred Brand & Non-Preferred Generic - **Tier 3**	$45 Copayment or 50%, greater of	Non-Preferred Brand & Non-Preferred Generic - **Tier 3** $130 Copayment or 45%, greater of ($400 max)

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.

Specialty Generic - **Tier 4**	$10 Copayment or 20%, greater of	Specialty Generic - **Tier 4**	$10 Copayment or 20%, greater of
Specialty Brand - **Tier 5**	$125 Copayment or 20%, greater of	Specialty Brand - **Tier 5**	$125 Copayment or 20%, greater of

*** After Deductible**

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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. 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.

Medical plan Copayments apply to the Medical Out-of-Pocket and Prescription drug Copayments apply to the Pescription drug Out-of-Pocket.

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AULTCARE

AULTERNATIVE PLANS SCHEDULE D 2800, 5000, 6650 & Max Limit
HEALTH SAVINGS ACCOUNT (HSA) COMPATIBLE
SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS	Aulternative D 2800		Aulternative D 5000		Aulternative D 6650		Aultra Max Limit D	
	Network	Non Network	Network	Non Network	Network	Non Network	Network	Non Network
Calendar Year Deductible								
Employee	$2,800	$8,400	$5,000	$15,000	$6,650	$19,950	$7,000	$21,000
Family	$5,600	$16,800	$10,000	$30,000	$13,300	$39,900	$14,000	$42,000
Benefit Level	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	100%*RBP
Medical Out-of-Pocket Maximum								
Employee	$2,800	$16,800	$5,000	$22,050	$6,650	$22,050	$7,000	$25,650
Family	$5,600	$33,600	$10,000	$44,100	$13,300	$44,100	$14,000	$51,300
Annual Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Emergency Services	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP
Urgent Care	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP
Preventive Health Services As defined by the Affordable Care Act.	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP
Maternity Care	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Inpatient Hospital Services	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Diagnostic Services (Labs, X-Rays)	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Outpatient Therapy Services	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Second Surgical Opinion	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Other Services Refer to plan benefit chart)	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Ambulance	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP
Physician Office Visits								
Visits for Illness / Injury	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Telemedicine	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Prescription Drugs	100%*		100%*		100%*		100%*	

*** After Deductible**

RBP stands for Reference Based Pricing

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. 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.

These plans are constructed to be HSA compatible. Therefore, Deductible will be indexed to correspond to IRS guidelines.

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.

AULTCARE

2021

AULTERNATIVE PLANS SCHEDULE E and F Plans
HEALTH SAVINGS ACCOUNT (HSA) COMPATIBLE
SCHEDULE OF HEALTH INSURANCE BENEFITS

MEDICAL BENEFITS	Aulternative E 1500***		Aulternative E 2500***		Aulternative F 2800****		Aulternative F 5000****	
	Network	Non Network	Network	Non Network	Network	Non Network	Network	Non Network
Calendar Year Deductible								
Employee	$1,500	$4,500	$2,500	$7,500	$2,800	$8,400	$5,000	$15,000
Family	$3,000	$9,000	$5,000	$15,000	$5,600	$16,800	$10,000	$30,000
Benefit Level	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Medical Out-of-Pocket Maximum								
Employee	$1,500	$9,000	$2,500	$15,000	$2,800	$16,800	$5,000	$22,050
Family	$3,000	$18,000	$5,000	$30,000	$5,600	$33,600	$10,000	$44,100
Annual Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Emergency Services	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP
Urgent Care	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP
Preventive Health Services As defined by the Affordable Care Act.	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP	100%	50%*RBP
Maternity Care	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Inpatient Hospital Services	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Diagnostic Servuces (Labs, X-Rays)	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Outpatient Therapy Services	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Second Surgical Opinion	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Other Services Refer to plan benefit chart	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Ambulance	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP	100%*	100%*RBP
Physician Office Visits								
Visits for Illness / Injury	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Telemedicine	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP	100%*	80%*RBP
Prescription Drugs	100% Copayment Prescription Copayments apply AFTER Medical Deductible of $1,500/individual or $3,000/family is met		100% Copayment Prescription Copayments apply AFTER Medical Deductible of $2,500/individual or $5,000/family is met		100% Copayment Prescription Copayments apply AFTER Medical Deductible of $2,800/individual or $5,600/family is met		100% Copayment Prescription Copayments apply AFTER Medical Deductible of $5,000/individual or $10,000/family is met	

Prescription Drugs	**Retail**	**Mail Order** (90 day supply)
Preferred Generic medications (1-34 days) - **Tier 1**	$10 Copayment	$25 Copayment
Preferred Generic medications (35-60 days) - **Tier 1**	$20 Copayment	
Preferred Brand & Non-Preferred Generic medications - **Tier 2**	$30 Copayment	$85 Copayment
Non-Preferred Brand & Non-Preferred Generic medications - **Tier 3**	$60 Copayment or 50%,	$170 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.		
Specialty Generic medications - **Tier 4**	$10 Copayment or 20%, greater of	$10 Copayment or 20%, greater of
Specialty Brand medications - **Tier 5**	$125 Copayment or 20%, greater of	$125 Copayment or 20%, greater of

No Prescription Copayments AFTER an additional Prescription Out-of-Pocket of $750/individual or $1,500/family is met	No Prescription Copayments AFTER an additional Prescription Out-of-Pocket of $750/individual or $1,500/family is met	No Prescription Copayments AFTER an additional Prescription Out-of-Pocket of $750/individual or $1,500/family is met	No Prescription Copayments AFTER an additional Prescription Out-of-Pocket of $750/individual or $1,500/family is met

RBP stands for Reference Based Pricing

*** After Deductible**

***** (E Plans) - 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.**

****** (F Plans) - 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.**

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.
These plans are constructed to be HSA compatible. Therefore, Deductible will be indexed to correspond to IRS guidelines.

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.