

Aulternative 1000/80 B Schedule of Health Insurance Benefits

Employee	
Prescription Drugs See Reverse side Prescription Drugs See Reverse side Preventive Health Services See www.healthcare.gov for additional information. Asteroid See Williams See See See See See See See See See S	Deductible and Out-of-Pocke
Medical Plan Out-of-Pocket Maximum	Maximum are Non-Integrated
Medical Plan Out-of-Pocket Maximum	Therefore, Deductible and Ou of-Pocket amounts met for
Employee \$2,000 \$4,000 New	Network Providers DO NOT
Physician Office Visits and Telemedicine	apply to Deductible and Out-c
Physician Office Visits and Telemedicine For Illness \$25 Copayment 60% UCR For Injury \$25 Copayment \$25 Copayment UCR Prescription Drugs See Reverse side Preventive Health Services As defined by the Affordable Care Act. See www.healthcare.gov for additional information. Maternity Care 80% 60% UCR Inpatient Hospital Services \$80% 60% UCR Diagnostic Services \$50 Copayment \$50 Copayment UCR Problem 100% 50% UCR Reverse side 50% UCR Problem 20% 50% UCR Reverse side 50% UCR Problem 20% 50% UCR Reverse side 50% UCR Problem 20% 50% UCR Reverse side 50% UCR	Pocket amounts met for Non-
Physician Office Visits and Telemedicine For Illness \$25 Copayment 60% UCR Up	Network Providers.
For Illness \$25 Copayment 60% UCR For Injury \$25 Copayment \$25 Copayment UCR	Embedded Deductible. Each
For Injury \$25 Copayment \$25 Copayment UCR To Injury \$25 Copayment \$25 Copayment UCR To Injury \$25 Copayment UCR \$25 Copayment \$25 Copayment \$25 Copayment \$25 Copayment \$25 Copayment UCR \$25 Copayment U	member of a family is looked
Prescription Drugs See Reverse side Preventive Health Services As defined by the Affordable Care Act. See www.healthcare.gov for additional information. Maternity Care Bo% 60% UCR Inpatient Hospital Services Emergency Services \$50 Copayment \$50 Copayment UCR Process \$60% UCR Process \$60% UCR Outpatient Therapy Services \$80% \$60% UCR Comparison of the Affordable Care Act. See www.healthcare.gov for additional information. The Comparison of the Affordable Care Act. See www.healthcare.gov for additional information. Process \$50 Copayment \$50 Copayment UCR Process \$60% UCR Outpatient Therapy Services \$80% \$60% UCR Other Services Refer to Summary Plan Description \$80% \$60% UCR	upon as an indvidiual in regard
Preventive Health Services As defined by the Affordable Care Act. See www.healthcare.gov for additional information. Maternity Care New Temperature of the Act o	to the Deductible. Once a member reaches the single
Preventive Health Services As defined by the Affordable Care Act. See www.healthcare.gov for additional information. Maternity Care Inpatient Hospital Services 80% 60% UCR 80% 6	Deductible, Coinsurance will
As defined by the Affordable Care Act. See www.healthcare.gov for additional information. Maternity Care	apply.
As defined by the Affordable Care Act. See www.healthcare.gov for additional information. Maternity Care	
the Affordable Care Act. See www.healthcare.gov for additional information. Maternity Care	Appropriate Deductible and
Inpatient Hospital Services Emergency Services Diagnostic Services (Labs, X-rays) Outpatient Therapy Services Services Outpatient Therapy Services Other Services Refer to Summary Plan Description 100% 50% UCR 60% UCR Diagnostic Services 80% 60% UCR	Copayment must be satisfied before any benefit is paid
See www.healthcare.gov for additional information. The Position	except as noted.
Maternity Care 80% 60% UCR Point	moops as notes.
Maternity Care80%60% UCRInpatient Hospital Services80%60% UCREmergency Services\$50 Copayment\$50 Copayment UCRDiagnostic Services (Labs, X-rays)80%60% UCROutpatient Therapy Services80%60% UCROther Services Refer to Summary Plan Description80%60% UCR	The Medical Plan Out-of-
Inpatient Hospital Services 80% 60% UCR Emergency Services \$50 Copayment \$50 Copayment UCR Diagnostic Services 80% 60% UCR Outpatient Therapy Services 80% 60% UCR Other Services Refer to Summary Plan Description 80% 60% UCR	Pocket Maximum amount
Inpatient Hospital Services 80% 60% UCR Emergency Services \$50 Copayment \$50 Copayment UCR Property Services 80% 60% UCR Labs, X-rays	includes the Deductible.
Emergency Services \$50 Copayment \$50 Copayment UCR Priding Diagnostic Services (Labs, X-rays) Outpatient Therapy Services 80% 60% UCR Other Services Refer to Summary Plan Description 80% 60% UCR	Deductible is waived for
Solution	Network Preventive Health
Diagnostic Services (Labs, X-rays) Outpatient Therapy Services Other Services Refer to Summary Plan Description Property Services 80% 60% UCR inc. Co. Co. Co. Co. Co. Co. Co. C	Services.
Diagnostic Services (Labs, X-rays) Outpatient Therapy Services Other Services Refer to Summary Plan Description 80% 60% UCR ind Co an in Co	Pre-Approval is recommended
(Labs, X-rays) Outpatient Therapy Services 80% 60% UCR inc Co Other Services Refer to Summary Plan Description 80% 60% UCR 60% UCR 60% UCR	for all Inpatient admissions.
Outpatient Therapy Services 80% 60% UCR indicates and an analysis of the Services Refer to Summary Plan Description 80% 60% UCR in an an analysis of the Services Refer to Summary In an analysis of the Services Refer to Sum	
Outpatient Therapy Services 80% 60% UCR Other Services Refer to Summary Plan Description 80% 60% UCR	Not all benefit descriptions,
Other Services Refer to Summary 80% 60% UCR in Co	exclusions and limitations are included in this document.
Other Services Refer to Summary 80% Plan Description 60% UCR	niciuaea in triis document. Complete benefit descriptions
Plan Description 80% GCR in Co	and exclusions are contained
	in the AultCare Insurance
	Company Certificates of
Ambulance 80% UCR	Coverage and Benefit Chart.
	Contact AultCare
Annual Plan Maximum UNLIMITED UNLIMITED wv	www.aultcare.com
	330-363-6360 1-800-344-8858



Prescription Drugs	Retail	Mail Order (60 day supply)	
Tier 1	\$10 Copayment or 20%,		
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	
Tier 2	greater of	333 Copayment	
Tier 3	\$45 Copayment or 50%,	¢110 Consument	
Tier 3	greater of	\$110 Copayment	
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained 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%,	
Tier 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 retai	l pharmacy	
A sixty (60) day sup	oly is available at the retail pharm	acy for Tier 1	
A sixty (60) day supply	may be obtained through the mai	il order program	

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

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.



Aulternative 1000/100 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-Pocket amounts met for
		•	Network Providers DO NOT
Medical Plan Out-of-Pocket Maximu	ım		apply to Deductible and Out-o
Employee	\$2,000	\$4,000	Pocket amounts met for Non-
Family	\$4,000	\$8,000	Network Providers.
•		•	Embedded Deductible. Each
Physician Office Visits and Telemedi	cine		member of a family is looked
For Illness	\$25 Copayment	80% UCR	upon as an indvidiual in regard
For Injury	\$25 Copayment	\$25 Copayment UCR	to the Deductible. Once a
		•	member reaches the single
Prescription Drugs	See Reverse side		Deductible, Coinsurance will apply.
•		•	_ ,
Preventive Health Services			Appropriate Deductible and
As defined by			Copayment must be satisfied
the Affordable Care Act.	1000/	F00/ LICD	before any benefit is paid
See www.healthcare.gov for	100%	50% UCR	except as noted.
additional information.			The Medical Plan Out-of-
			Pocket Maximum amount
Maternity Care	100%	80% UCR	includes the Deductible.
			Beductible to well-offer
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
Diagnostic Services	4000/	000/1105	for all Inpatient admissions.
(Labs, X-rays)	100%	80% UCR	Not all benefit descriptions,
		•	exclusions and limitations are
Outpatient Therapy Services	100%	80% UCR	included in this document.
		•	Complete benefit descriptions
Other Services Refer to Summary	40051	0000000	and exclusions are contained
Plan Description	100%	80% UCR	in the AultCare Insurance
		•	Company Certificates of
Ambulance	100%	100% UCR	Coverage and Benefit Chart.
			Contact AultCare
Annual Plan Maximum	UNLIMITED	UNLIMITED	www.aultcare.com
	0.12		330-363-6360
			1-800-344-8858



Prescription Drugs	Retail	Mail Order (60 day supply)	
Tier 1	\$10 Copayment or 20%,	\$27 Canayment	
1-34 day supply	greater of	\$27 Copayment	
Tier 1	\$27 Canaymant		
35-60 day supply	\$27 Copayment		
Tier 2	\$20 Copayment or 30%,	¢EE Canayment	
Tier 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 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%,	
Tier 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 retai	l pharmacy	
A sixty (60) day sup	ply is available at the retail pharm	acy for Tier 1	
A sixty (60) day supply may be obtained through the mail order program			

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

- **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.



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-Pocket amounts met for
			Network Providers DO NOT
Medical Plan Out-of-Pocket Maximu	ım		apply to Deductible and Out-o
Employee	\$2,500	\$6,000	Pocket amounts met for Non-
Family	\$5,000	\$12,000	Network Providers.
<u> </u>			Embedded Deductible. Each
Physician Office Visits and Telemed			member of a family is looked
For Illness	\$25 Copayment	70% UCR	upon as an indvidiual in regard
For Injury	\$25 Copayment	\$25 Copayment UCR	to the Deductible. Once a member reaches the single
			Deductible, Coinsurance will
Prescription Drugs	See Reverse side		apply.
[Ammonuista Dadustible and
Preventive Health Services			Appropriate Deductible and Copayment must be satisfied
As defined by			before any benefit is paid
the Affordable Care Act.	100%	50% UCR	except as noted.
See www.healthcare.gov for			
additional information.			The Medical Plan Out-of-
Bastonnito Cono	000/	700/ HCD	Pocket Maximum amount
Maternity Care	90%	70% UCR	inclides the Deductible.
Inpatient Hospital Services	90%	70% UCR	Deductible is waived for
inpatient Hospital Services	3070	70% 001	Network Preventive Health
Emergency Services	\$150 Copayment	\$150 Copayment UCR	Services.
zmergency services	7130 copayment	\$130 copayment och	Pre-Approval is recommended
Diagnostic Services			for all Inpatient admissions.
(Labs, X-rays)	90%	70% UCR	
[2000]			Not all benefit descriptions,
Outpatient Therapy Services	90%	70% UCR	exclusions and limitations are included in this document.
outputient merupy services	3070	7070 0011	Complete benefit descriptions
Other Services Refer to Summary			and exclusions are contained
Plan Description	90%	70% UCR	in the AultCare Insurance
		1	Company Certificates ofCoverage and Benefit Chart.
Ambulance	90%	90% UCR	Coverage and benefit chart.
'		'	Contact AultCare
Annual Plan Maximum	UNLIMITED	UNLIMITED	www.aultcare.com
		•	330-363-6360 1-800-344-8858



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	
Tier 2	greater of	\$55 Copayment	
Tion 2	\$45 Copayment or 50%,	¢110 Congument	
Tier 3	greater of	\$110 Copayment	
Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted			
Specialty Network pharmacy. Limited to a 30 day supply.			
Tier 4	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
Tier 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) a	lay supply is available at the retai	l pharmacy	
A sixty (60) day supp	ly is available at the retail pharm	acy for Tier 1	
A sixty (60) day supply may be obtained through the mail order program			

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.



Aulternative 1500/100 B

Schedule of Health Insurance Benefits

Non-Network

Network

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			= -
Calendar Year Deductible			Deductible and
Employee	\$1,500	\$3,000	Maximum are N Therefore, Dedu
Family	\$3,000	\$6,000	of-Pocket amou
			Network Provide
Medical Plan Out-of-Pocket Maximu			apply to Deduct
Employee	\$1,500	\$6,000	Pocket amounts Network Provide
Family	\$3,000	\$12,000	Network Flovide
<u></u>			Embedded Ded
Physician Office Visits and Telemed		_	member of a far
For Illness	\$25 Copayment	80% UCR	upon as an indvi
For Injury	\$25 Copayment	\$25 Copayment UCR	to the Deductibl member reache
			Deductible, Coir
Prescription Drugs	See Reverse side		apply.
Preventive Health Services			Appropriate De
As defined by		1	Copayment mus
the Affordable Care Act.			before any bene
See www.healthcare.gov for	100%	50% UCR	except as noted
additional information.			The Medical Pla
		•	Pocket Maximur
Maternity Care	100%	80% UCR	includes the Dec
Inpatient Hospital Services	100%	80% UCR	Deductible is wa
inpatient nospital services	10070	30% CCN	Network Prever
Emergency Services	\$150 Copayment	\$150 Copayment UCR	Services.
3,	1 1	,,	Pre-Approval is
Urgent Care	\$50 Copayment	\$50 Copayment UCR	for all Inpatient
			— → Not all benefit d
Diagnostic Services	100%	80% UCR	exclusions and li
(Labs, X-rays)	100/0	30% 35%	included in this o
			Complete benefit
Outpatient Therapy Services	100%	80% UCR	and exclusions a in the AultCare I
			Company Certifi
Other Services Refer to Summary	100%	80% UCR	Coverage and Be
Plan Description	100/0	0070 0011	_
			Contact AultCar
Ambulance	100%	100% UCR	www.aultcare.co
			1 -800-344-8858
Annual Plan Maximum	UNLIMITED	UNLIMITED	

Out-of-Pocket on-Integrated.

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n Out-ofn amount uctible.

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ecommended admissions.

escriptions, mitations are locument. t descriptions re contained nsurance cates of enefit Chart.

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

Medical Benefits



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 Canaymant			
35-60 day supply	\$27 Copayment			
Tier 2	\$20 Copayment or 30%,	\$55 Copayment		
Tier 2	greater of	333 сораунтент		
Tier 3	\$45 Copayment or 50%,	¢110 Canaymant		
Tier 3	greater of	\$110 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 Network pharmacy . Limited to a 30 day supply.				
Tier 4	\$125 Copayment or 20%,	\$125 Copayment or 20%,		
Tier 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				

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

- **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.



Aulternative 2000/80 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 Providers DO NOT
Medical Plan Out-of-Pocket Maximu	m		apply to Deductible and Out-o
Employee	\$4,000	\$8,000	Pocket amounts met for Non-
Family	\$8,000	\$16,000	Network Providers.
•		•	Embedded Deductible. Each
Physician Office Visits and Telemedi	cine		member of a family is looked
For Illness	\$25 Copayment	60% UCR	upon as an indvidiual in regard
For Injury	\$25 Copayment	\$25 Copayment UCR	to the Deductible. Once a
	. ,		member reaches the single
Prescription Drugs	See Reverse side		Deductible, Coinsurance will apply.
		1	
Preventive Health Services			Appropriate Deductible and
As defined by		T	Copayment must be satisfied
the Affordable Care Act.	1000/	500/1100	before any benefit is paid
See www.healthcare.gov for	100%	50% UCR	except as noted.
additional information.			The Medical Plan Out-of-
•		•	Pocket Maximum amount
Maternity Care	80%	60% UCR	includes the Deductible.
•		•	
Inpatient Hospital Services	80%	60% UCR	Deductible is waived for
			Network Preventive HealthServices.
Emergency Services	\$50 Copayment	\$50 Copayment UCR	Services.
<u> </u>	. ,	' ' '	Pre-Approval is recommended
Diagnostic Services			for all Inpatient admissions.
(Labs, X-rays)	80%	60% UCR	
1-2-2-7			Not all benefit descriptions,
Outpatient Therapy Services	80%	60% UCR	exclusions and limitations are included in this document.
outputient incrupy services	3070	00% GEN	Complete benefit descriptions
Other Services Refer to Summary			and exclusions are contained
Plan Description	80%	60% UCR	in the AultCare Insurance
רומוו שפגנווףנוטוו		I	Company Certificates of
Ambulance	80%	80% UCR	Coverage and Benefit Chart.
Ambulance	OU/0	00% UCK	Contact AultCare
Annual Dian Manissess	LINILINAITED	LINILINALTED	www.aultcare.com
Annual Plan Maximum	UNLIMITED	UNLIMITED	330-363-6360
			1-800-344-8858



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 Canaumant		
35-60 day supply	\$27 Copayment		
Tier 2	\$20 Copayment or 30%,	¢EE Consument	
Tier 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 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%,	
Tier 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) o	day supply is available at the retai	l pharmacy	
A sixty (60) day supp	oly is available at the retail pharm	acy for Tier 1	
A sixty (60) day supply may be obtained through the mail order program			

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

Tier 1	is defined	as Preferred	Generic medications.
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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.



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 Our of-Pocket amounts met for
		•	Network Providers DO NOT
Medical Plan Out-of-Pocket Maximu	ım		apply to Deductible and Out-o
Employee	\$2,000	\$8,000	Pocket amounts met for Non-
Family	\$4,000	\$16,000	Network Providers.
			Embedded Deductible. Each
Physician Office Visits and Telemed	icine		member of a family is looked
For Illness	\$25 Copayment	80% UCR	upon as an indvidiual in regard
For Injury	\$25 Copayment	\$25 Copayment UCR	to the Deductible. Once a member reaches the single
,		_	Deductible, Coinsurance will
Prescription Drugs	See Reverse side		apply.
Preventive Health Services		_	Appropriate Deductible and Copayment must be satisfied
As defined by			before any benefit is paid
the Affordable Care Act.	100%	50% UCR	except as noted.
See www.healthcare.gov for additional information.			
uduktonai injormation.		<u> </u>	The Medical Plan Out-of-
Maternity Care	100%	80% UCR	Pocket Maximum amount includes the Deductible.
,		,	
Inpatient Hospital Services	100%	80% UCR	Deductible is waived for
, , , , , , , , , , , , , , , , , , ,			Network Preventive Health
Emergency Services	\$50 Copayment	\$50 Copayment UCR	Services.
	· ,		Pre-Approval is recommended
Diagnostic Services	1000/	900/ 1100	for all Inpatient admissions.
(Labs, X-rays)	100%	80% UCR	Not all benefit descriptions,
·		•	exclusions and limitations are
Outpatient Therapy Services	100%	80% UCR	included in this document.
			Complete benefit descriptions
Other Services Refer to Summary	100%	80% UCR	and exclusions are contained in the AultCare Insurance
Plan Description	100/0	00/0 OCI	Company Certificates of
<u> </u>		_	Coverage and Benefit Chart.
Ambulance	100%	100% UCR	
		1	Contact AultCare
Annual Plan Maximum	UNLIMITED	UNLIMITED	www.aultcare.com 330-363-6360
			1-800-344-8858



Prescription Drugs	Retail	Mail Order (60 day supply)	
Tier 1	\$10 Copayment or 20%,	\$27 Copayment	
1-34 day supply	greater of		
Tier 1	\$27 Copayment		
35-60 day supply	327 Copayment		
Tier 2	\$20 Copayment or 30%,	\$55 Copayment	
Her 2	greater of	333 Copayment	
T' 2	\$45 Copayment or 50%,	\$110 Canaymant	
Tier 3	greater of	\$110 Copayment	
Tier 4 and 5 - Prior Authorization is require	red. 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%,	
	greater of	greater of	
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
	greater of	greater of	
A thirty four (34) a	day supply is available at the retai	l pharmacy	
A sixty (60) day supp	oly is available at the retail pharm	acy for Tier 1	
A sixty (60) day supply	may be obtained through the mai	il order program	

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

Tier 1	is defined	as Preferred	Generic medications.	
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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.



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 Providers DO NOT
Medical Plan Out-of-Pocket Maximu	ım		apply to Deductible and Out-o
Employee	\$2,500	\$8,000	Pocket amounts met for Non-
Family	\$5,000	\$16,000	Network Providers.
			Embedded Deductible. Each
Physician Office Visits and Telemedi			member of a family is looked
For Illness	\$25 Copayment	80% UCR	upon as an indvidiual in regard
For Injury	\$25 Copayment	\$25 Copayment UCR	to the Deductible. Once a member reaches the single
			Deductible, Coinsurance will
Prescription Drugs	See Reverse side		apply.
r			
Preventive Health Services			Appropriate Deductible and Copayment must be satisfied
As defined by			before any benefit is paid
the Affordable Care Act.	100%	50% UCR	except as noted.
See www.healthcare.gov for			·
additional information.		L	The Medical Plan Out-of-
Maternity Care	100%	80% UCR	Pocket amount includes the Deductible.
iviateriiity care	100%	80% OCK	Deductible.
Inpatient Hospital Services	100%	80% UCR	Deductible is waived for
inputient Hospital Sci vices	10070	2070 0011	Network Preventive Health
Emergency Services	\$50 Copayment	\$50 Copayment UCR	Services.
,		· · · · ·	Pre-Approval is recommended
Diagnostic Services	1000/	200/1105	for all Inpatient admissions.
(Labs, X-rays)	100%	80% UCR	Not all bonefit descriptions
		•	Not all benefit descriptions, exclusions and limitations are
Outpatient Therapy Services	100%	80% UCR	included in this document.
<u> </u>		•	Complete benefit descriptions
Other Services Refer to Summary	100%	80% UCR	and exclusions are contained in the AultCare Insurance
Plan Description	100/0	00/0 UCN	Company Certificates of
			Coverage and Benefit Chart.
Ambulance	100%	100% UCR	
			Contact AultCare
Annual Plan Maximum	UNLIMITED	UNLIMITED	www.aultcare.com 330-363-6360
			1-800-344-8858



Prescription Drugs	Retail	Mail Order (60 day supply)	
Tier 1	\$10 Copayment or 20%,	\$27 Copayment	
1-34 day supply	greater of		
Tier 1	\$27 Consument		
35-60 day supply	\$27 Copayment		
Tier 2	\$20 Copayment or 30%,	¢EE Consument	
Tier 2	greater of	\$55 Copayment	
Tier 3	\$45 Copayment or 50%,	¢110 Congument	
	greater of	\$110 Copayment	
Tier 4 and 5 - Prior Authorization is requir	ed. Medications must be obtain	ed 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%,	
	greater of	greater of	
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
	greater of	greater of	
A thirty four (34) a	lay supply is available at the retai	l pharmacy	
A sixty (60) day supp	ly is available at the retail pharm	acy for Tier 1	
A sixty (60) day supply	may be obtained through the mai	il order program	

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

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.



Aulternative 5000 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network	=
Calendar Year Deductible			Deductible and Out-of-Pocket
Employee	\$5,000	\$7,500	Maximum are Non-Integrated
Family	\$10,000	\$15,000	Therefore, Deductible and Out of-Pocket amounts met for
		•	Network Providers DO NOT
Medical Plan Out-of-Pocket Maximu	m		apply to Deductible and Out-o
Employee	\$5,000	\$10,000	Pocket amounts met for Non-
Family	\$10,000	\$20,000	Network Providers.
		•	Embedded Deductible. Each
Physician Office Visits and Telemedi	cine		member of a family is looked
For Illness	\$25 Copayment	80% UCR	upon as an indvidiual in regard
For Injury	\$25 Copayment	\$25 Copayment UCR	to the Deductible. Once a
	. ,	,	member reaches the single
Prescription Drugs	See Reverse side		Deductible, Coinsurance will apply.
		1	арріу.
Preventive Health Services			Appropriate Deductible and
As defined by			Copayment must be satisfied
the Affordable Care Act.			before any benefit is paid
See www.healthcare.gov for	100%	50% UCR	except as noted.
additional information.			The Medical Plan Out-of-
		•	Pocket Maximum amount
Maternity Care	100%	80% UCR	includes the Deductible.
		1	_
Inpatient Hospital Services	100%	80% UCR	Deductible is waived for
process and the second			Network Preventive Health
Emergency Services	\$50 Copayment	\$50 Copayment UCR	Services.
zmergency certified	yoo copayment	yse copayment sent	Pre-Approval is recommended
Diagnostic Services			for all Inpatient admissions.
(Labs, X-rays)	100%	80% UCR	
(Edds, A ruys)		1	Not all benefit descriptions,
Outpatient Therapy Services	100%	80% UCR	exclusions and limitations are
Outpatient Therapy Services	100%	80% UCR	included in this document. Complete benefit descriptions
Other Comises D.C. 1. C.		T	and exclusions are contained
Other Services Refer to Summary	100%	80% UCR	in the AultCare Insurance
Plan Description		L	Company Certificates of
Ambulana	1000/	1000/ 1100	Coverage and Benefit Chart.
Ambulance	100%	100% UCR	Contact Ault Cons
			Contact AultCare www.aultcare.com
Annual Plan Maximum	UNLIMITED	UNLIMITED	330-363-6360
			1-800-344-8858



Prescription Drugs	Retail	Mail Order (60 day supply)	
Tier 1	\$10 Copayment or 20%,	\$27 Copayment	
1-34 day supply	greater of		
Tier 1	\$27 Copayment		
35-60 day supply	327 Copayment		
Tier 2	\$20 Copayment or 30%,	\$55 Copayment	
Her 2	greater of	333 Copayment	
T' 2	\$45 Copayment or 50%,	\$110 Canaymant	
Tier 3	greater of	\$110 Copayment	
Tier 4 and 5 - Prior Authorization is require	red. 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%,	
	greater of	greater of	
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
	greater of	greater of	
A thirty four (34) a	day supply is available at the retai	l pharmacy	
A sixty (60) day supp	oly is available at the retail pharm	acy for Tier 1	
A sixty (60) day supply	may be obtained through the mai	il order program	

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