

Canton Regional Chamber Health Fund 5000 F

Health Savings Account (HSA) Compatible Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$5,000	\$15,000
Family	\$10,000	\$30,000
Medical Plan Out-of-Pocket Maxi	mum	
Employee	\$5,000	\$22,050
Family	\$10,000	\$44,100
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Prescription Drug Out-of-Pocket		
Employee	\$750	N/A
Family	\$1,500	N/A
Physician Office Visits and Telem	edicine	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for	100/0	30% (12)
additional information.		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
inputient mospital services	10070	00% NDI
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
orgenic care	100/0	100% NBF
Diagnostic Services	100%	900/ ppp
(Labs, X-rays)	100%	80% RBP
Output Thousand Commission	1000/	000/ 000
Outpatient Therapy Services	100%	80% RBP
Other Services Refer to Summary	100%	900/ PPP
Plan Description	100%	80% RBP
Ambulance	100%	100% RBP
	100/0	100/8 ((D)
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.

Deductible is waived for Network Preventive Health Services.

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

Once the Medical Plan Deductible and 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 copayments will be waived.

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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

Prescription Copayments and Coinsurance apply after medical Deductible of \$5,000 per Covered Person or \$10,000 per Family is met.

Prescription Drugs	Retail	Mail Order (90 day supply)	
Tier 1 - 1-34 day supply	\$10 Copayment	\$25 Copayment	
Tier 1 - 35-60 day supply	\$20 Copayment		
Tier 2	\$30 Copayment	\$85 Copayment	
Tier 3	\$60 Copayment or 50%, greater of	\$170 Copayment	
Tier 4 and 5 - Prior Authorization is req	Tier 4 and 5 - Prior Authorization is required. Medications must be obtained through an AultCare contracted		
Specialty Net	work pharmacy. Limited to a 30	day supply.	
Tier 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,	
Tier 4	greater of	greater of	
T' 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,	
Tier 5	greater of	greater of	
A thirty four (34	l) day supply is available at the re	tail pharmacy	
A sixty (60) day sı	ipply is available at the retail pha	rmacy for Tier 1	
A ninety (90) day sup	ply may be obtained through the	mail order program	

No Pescription Copayments after an additional Prescription Out-of-Pocket of \$750 per Covered Person or \$1,500 per Family is met.

Tier Definitions

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

Tier 1	is defined as Preferred Generic medications	c
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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



Canton Regional Chamber Health Fund 3200 D

Health Savings Account (HSA) Compatible Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$3,200	\$9,600
Family	\$6,400	\$19,200
Out-of-Pocket Maximum		
Employee	\$3,200	\$17,350
Family	\$6,400	\$34,700
Physician Office Visits and Telemedi	cine	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs (Follow Premium Managed Formulary)	100%	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
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
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Deductible and Out-of-Pocket Maximum are Non-Integrated. Therefore, Deductible and Outof-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 is waived for **Network Preventive Health** Services.

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

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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



Canton Regional Chamber Health Fund 5000 D

Health Savings Account (HSA) Compatible Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$5,000	\$15,000
Family	\$10,000	\$30,000
Out-of-Pocket Maximum		
Employee	\$5,000	\$22,050
Family	\$10,000	\$44,100
Physician Office Visits and Telemedic	cine	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs (Follow Premium Managed Formulary)	100%	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
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 Outof-Pocket amounts met for
Network Providers <u>DO NOT</u>
apply to Deductible and Out-ofPocket amounts met for NonNetwork 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 is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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



Canton Regional Chamber Health Fund 6650 D

Health Savings Account (HSA) Compatible Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$6,650	\$19,950
Family	\$13,300	\$39,900
Out-of-Pocket Maximum		
Employee	\$6,650	\$22,050
Family	\$13,300	\$44,100
Physician Office Visits and Telemedic	ine	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs (Follow Premium Managed Formulary)	100%	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
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 Outof-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 is waived for **Network Preventive Health** Services.

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

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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Canton Regional Chamber Health Fund Maximum Limit D Plan Health Savings Account (HSA) Compatible Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$8,050	\$24,150
Family	\$16,100	\$48,300
Out-of-Pocket Maximum		
Employee	\$8,050	\$28,350
Family	\$16,100	\$56,700
Physician Office Visits and Telemedic	cine	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs (Follow Premium Managed Formulary)	100%	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
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 Outof-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 is waived for **Network Preventive Health** Services.

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

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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



Canton Regional Chamber Health Fund 500/80 B **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$500	\$1,500
Family	\$1,000	\$3,000
Medical Plan Out-of-Pocket Maxi	mum	
Employee	\$4,500	\$13,500
Family	\$9,000	\$27,000
Prescription Drug Out-of-Pocket I	Maximum Separate from	Medical
Employee	\$4,950	N/A
Family	\$9,900	N/A
Physician Office Visits and Telemo	edicine	
Illness/Injury	\$25 Copayment	60% RBP
Behavioral Health	\$25 Copayment	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%	50% RBP
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services (Labs, X-rays)	80%	60% RBP
Outpatient Therapy Services	80%	60% RBP
Other Services Refer to Summary Plan Description	80%	60% RBP
Ambulance	80%	80% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED
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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.

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
Her 2	greater of	greater of (\$200 max)
Tier 3	\$45 Copayment or 50%,	\$130 Copayment or 45%,
1161 3	greater of	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.

Tier 4	\$10 Copayment or 20%,	\$10 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 ninety (90) day supply may be obtained through the mail order program

There is an Out of Pocket Maximum of \$4,950 per Covered Person or \$9,900 per Family. Once this Maximum is met, Prescription Copayments will be waived.

Tier Definitions

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.

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



Canton Regional Chamber Health Fund 1000/100 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$1,000	\$3,000
Family	\$2,000	\$6,000
Medical Plan Out-of-Pocket Maxim	num	
Employee	\$1,000	\$6,000
Family	\$2,000	\$12,000
Prescription Drug Out-of-Pocket M	aximum Separate from	Medical
Employee	\$8,450	N/A
Family	\$16,900	N/A
Physician Office Visits and Telemed	dicine	
Illness/Injury	\$25 Copayment	80% RBP
Behavioral Health	\$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment 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 <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.

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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Retail	Mail Order (90 day supply)
\$10 Copayment or 20%,	\$25 Copayment or 20%,
greater of	greater of
\$20 Copayment or 20%,	
greater of	
\$30 Copayment or 30%,	\$85 Copayment or 25%,
greater of	greater of (\$200 max)
\$45 Copayment or 50%,	\$130 Copayment or 45%,
greater of	greater of (\$400 max)
	\$10 Copayment or 20%, greater of \$20 Copayment or 20%, greater of \$30 Copayment or 30%, greater of \$45 Copayment or 50%,

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.

T' 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Tier 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 ninety (90) day supply may be obtained through the mail order program

There is an Out of Pocket Maximum of \$8,450 per Covered Person or \$16,900 per Family.

Once this Maximum is met, Prescription Copayments will be waived.

Tier Definitions

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.

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



Canton Regional Chamber Health Fund 1500/80 B Schedule of Health Insurance Benefits

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Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$1,500	\$4,500
Family	\$3,000	\$9,000
Medical Plan Out-of-Pocket Maxim	num	
Employee	\$2,500	\$7,500
Family	\$5,000	\$15,000
Prescription Drug Out-of-Pocket M	laximum Separate from	Medical
Employee	\$6,950	N/A
Family	\$13,900	N/A
Physician Office Visits and Teleme	dicine	
Illness/Injury	\$25 Copayment	60% RBP
Behavioral Health	\$25 Copayment	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%	50% RBP
Maternity Care	80%	60% RBP
Inpatient Hospital Services	80%	60% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services (Labs, X-rays)	80%	60% RBP
Outpatient Therapy Services	80%	60% RBP
Other Services Refer to 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 <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.

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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

Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
Her 2	greater of	greater of (\$200 max)
Tier 3	\$45 Copayment or 50%,	\$130 Copayment or 45%,
Her 5	greater of	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.

T' 4	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Tier 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 ninety (90) day supply may be obtained through the mail order program

There is an Out of Pocket Maximum of \$6,950 per Covered Person or \$13,900 per Family.

Once this Maximum is met, Prescription Copayments will be waived.

Tier Definitions

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.

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



Canton Regional Chamber Health Fund 1500/100 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$1,500	\$4,500
Family	\$3,000	\$9,000
Medical Plan Out-of-Pocket Maxin	num	
Employee	\$1,500	\$9,000
Family	\$3,000	\$18,000
Prescription Drug Out-of-Pocket M	laximum Separate from	Medical
Employee	\$7,950	N/A
Family	\$15,900	N/A
Physician Office Visits and Teleme	dicine	
Illness/Injury	\$25 Copayment	80% RBP
Behavioral Health	\$25 Copayment	80% RBP
Prescription Drugs See reverse side	2	
Preventive Health Services		
As defined by the Affordable Care Act. See www.healthcare.gov for additional information.	100%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment 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
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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.

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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

Retail	Mail Order (90 day supply)
\$10 Copayment or 20%,	\$25 Copayment or 20%,
greater of	greater of
\$20 Copayment or 20%,	
greater of	
\$30 Copayment or 30%,	\$85 Copayment or 25%,
greater of	greater of (\$200 max)
\$45 Copayment or 50%,	\$130 Copayment or 45%,
greater of	greater of (\$400 max)
	\$10 Copayment or 20%, greater of \$20 Copayment or 20%, greater of \$30 Copayment or 30%, greater of \$45 Copayment or 50%,

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	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Het 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 ninety (90) day supply may be obtained through the mail order program

There is an Out of Pocket Maximum of \$7,950 per Covered Person or \$15,900 per Family.

Once this Maximum is met, Prescription Copayments will be waived.

Tier Definitions

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.

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



Canton Regional Chamber Health Fund 2000/100 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$2,000	\$6,000
Family	\$4,000	\$12,000
Medical Plan Out-of-Pocket Maxim	um	
Employee	\$2,000	\$12,000
Family	\$4,000	\$24,000
Prescription Drug Out-of-Pocket Ma	aximum Separate from	n Medical
Employee	\$7,450	N/A
Family	\$14,900	N/A
Physician Office Visits and Telemed	licine	
Illness/Injury	\$25 Copayment	80% RBP
Behavioral Health	\$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment 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 <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.

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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

Retail	Mail Order (90 day supply)
\$10 Copayment or 20%,	\$25 Copayment or 20%,
greater of	greater of
\$20 Copayment or 20%,	
greater of	
\$30 Copayment or 30%,	\$85 Copayment or 25%,
greater of	greater of (\$200 max)
\$45 Copayment or 50%,	\$130 Copayment or 45%,
greater of	greater of (\$400 max)
	\$10 Copayment or 20%, greater of \$20 Copayment or 20%, greater of \$30 Copayment or 30%, greater of \$45 Copayment or 50%,

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	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Het 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 ninety (90) day supply may be obtained through the mail order program

There is an Out of Pocket Maximum of \$7,450 per Covered Person or \$14,900 per Family. Once this Maximum is met, Prescription Copayments will be waived.

Tier Definitions

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



Canton Regional Chamber Health Fund 2500/100 B **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$2,500	\$7,500
Family	\$5,000	\$15,000
Medical Plan Out-of-Pocket Maxim	um	
Employee	\$2,500	\$15,000
Family	\$5,000	\$30,000
Prescription Drug Out-of-Pocket Ma	aximum Separate from	n Medical
Employee	\$6,950	N/A
Family	\$13,900	N/A
Physician Office Visits and Telemed	licine	
Illness/Injury	\$25 Copayment	80% RBP
Behavioral Health	\$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment 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.

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

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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

Retail	Mail Order (90 day supply)
\$10 Copayment or 20%,	\$25 Copayment or 20%,
greater of	greater of
\$20 Copayment or 20%,	
greater of	
\$30 Copayment or 30%,	\$85 Copayment or 25%,
greater of	greater of (\$200 max)
\$45 Copayment or 50%,	\$130 Copayment or 45%,
greater of	greater of (\$400 max)
	\$10 Copayment or 20%, greater of \$20 Copayment or 20%, greater of \$30 Copayment or 30%, greater of \$45 Copayment or 50%,

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	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Her 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
	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 ninety (90) day supply may be obtained through the mail order program

There is an Out of Pocket Maximum of \$6,950 per Covered Person or \$13,900 per Family.

Once this Maximum is met, Prescription Copayments will be waived.

Tier Definitions

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.

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



Canton Regional Chamber Health Fund 3000/100 B Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$3,000	\$9,000
Family	\$6,000	\$18,000
Medical Plan Out-of-Pocket Maxim	um	
Employee	\$3,000	\$18,000
Family	\$6,000	\$36,000
Prescription Drug Out-of-Pocket Ma	aximum Separate from	n Medical
Employee	\$6,450	N/A
Family	\$12,900	N/A
Physician Office Visits and Telemed	licine	
Illness/Injury	\$25 Copayment	80% RBP
Behavioral Health	\$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment 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 <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.

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.

Deductible is waived for Network Preventive Health Services.

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

Prescription drug Copayments and Coinsurance apply to the Prescription drug Out-of-Pocket. Once this Maximum is met, Prescription Copayments will be waived.

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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

Retail	Mail Order (90 day supply)
\$10 Copayment or 20%,	\$25 Copayment or 20%,
greater of	greater of
\$20 Copayment or 20%,	
greater of	
\$30 Copayment or 30%,	\$85 Copayment or 25%,
greater of	greater of (\$200 max)
\$45 Copayment or 50%,	\$130 Copayment or 45%,
greater of	greater of (\$400 max)
	\$10 Copayment or 20%, greater of \$20 Copayment or 20%, greater of \$30 Copayment or 30%, greater of \$45 Copayment or 50%,

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	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Her 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
	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 ninety (90) day supply may be obtained through the mail order program

There is an Out of Pocket Maximum of \$6,450 per Covered Person or \$12,900 per Family.

Once this Maximum is met, Prescription Copayments will be waived.

Tier Definitions

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.

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



Canton Regional Chamber Health Fund 5000/100 B **Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$5,000	\$15,000
Family	\$10,000	\$30,000
Medical Plan Out-of-Pocket Maxi	mum	
Employee	\$9,450	\$28,350
Family	\$18,900	\$56,700
Prescription Drug Out-of-Pocket I	Maximum	
Employee	Integrated v	vith Medical
Family	Network Ou	it-of-Pocket
Physician Office Visits and Telemo	edicine	
Illness/Injury	\$25 Copayment	80% RBP
Behavioral Health	\$25 Copayment	80% RBP
Prescription Drugs	See Reverse side	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for additional information.		
Maternity Care	100%	80% RBP
waternity care		
Inpatient Hospital Services	100%	80% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment RBP
Diagnostic Services	100%	80% RBP
(Labs, X-rays)	100%	0U% KDP
Outpatient Therapy Services	100%	80% RBP
Other Services Refer to	100%	80% RBP
Summary Plan Description	100%	0U70 KBP
Ambulance	100%	100% RBP
Annual Plan Maximum	UNLIMITED	UNLIMITED
<u> </u>		

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.

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.

Deductible is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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

Retail	Mail Order (90 day supply)
\$10 Copayment or 20%,	\$25 Copayment or 20%,
greater of	greater of
\$20 Copayment or 20%,	
greater of	
\$30 Copayment or 30%,	\$85 Copayment or 25%,
greater of	greater of (\$200 max)
\$45 Copayment or 50%,	\$130 Copayment or 45%,
greater of	greater of (\$400 max)
	\$10 Copayment or 20%, greater of \$20 Copayment or 20%, greater of \$30 Copayment or 30%, greater of \$45 Copayment or 50%,

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	\$10 Copayment or 20%,	\$10 Copayment or 20%,
1161 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
	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 ninety (90) 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.
- **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



Canton Regional Chamber Health Fund Maximum Limit B Plan Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$9,450	\$24,300
Family	\$18,900	\$48,600
Medical Plan Out-of-Pocket Maxim	um	
Employee	\$9,450	\$28,350
Family	\$18,900	\$56,700
Prescription Drug Out-of-Pocket Ma	aximum	
Employee		l with Medical
Family	-	Out-of-Pocket
Physician Office Visits and Telemed	licine	
Illness/Injury	\$25 Copayment	80% RBP
Behavioral Health	\$25 Copayment	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%	50% RBP
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	\$150 Copayment	\$150 Copayment RBP
Urgent Care	\$50 Copayment	\$50 Copayment 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 <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.

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.

Deductible is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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

Prescription Drugs	Retail	Mail Order (90 day supply)
Tier 1 -	\$10 Copayment or 20%,	\$25 Copayment or 20%,
1-34 day supply	greater of	greater of
Tier 1 -	\$20 Copayment or 20%,	
35-60 day supply	greater of	
Tier 2	\$30 Copayment or 30%,	\$85 Copayment or 25%,
Her 2	greater of	greater of (\$200 max)
Tier 3	\$45 Copayment or 50%,	\$130 Copayment or 45%,
	greater of	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.

<u>-</u>	\$10 Copayment or 20%,	\$10 Copayment or 20%,
Tier 4	greater of	greater of
Tier 5	\$125 Copayment or 20%,	\$125 Copayment or 20%,
	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 ninety (90) 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.
- **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



Canton Regional Chamber Health Fund 1600 A

Health Savings Account (HSA) Compatible Schedule of Health Insurance Benefits

Medical Benefits	Network	Non-Network
Calendar Year Deductible		
Employee	\$1,600	\$4,800
Family	\$3,200	\$9,600
Out-of-Pocket Maximum		
Employee	\$1,600	\$9,600
Family	\$3,200	\$19,200
Physician Office Visits and Telem	edicine	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs (Follow		
Premium Managed Formulary)	100%	
Preventive Health Services		
As defined by		
the Affordable Care Act.	100%	50% RBP
See www.healthcare.gov for	100%	50% KBP
additional information .		
Maternity Care	100%	80% RBP
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
orgent care	100/6	100% KBF
Diagnostic Services	100%	80% RBP
(Labs, X-rays)	10070	0070 IVBI
Outpatient Therapy Services	100%	80% RBP
Other Services (Refer to	1000/	000/ ppp
Summary Plan Description)	100%	80% RBP
Ambulance	100%	100% RBP

Deductible and Out-of-Pocket aximum are Non-Integrated. nerefore, Deductible and Out--Pocket amounts met for etwork Providers **DO NOT** ply to Deductible and Out-ofocket amounts met for Nonetwork Providers.

nembedded Deductible. tire family deductible must met before any plan syments are made for any dividual family member.

propriate Deductible must satisfied before any benefit paid except as noted.

eductible is waived for etwork Preventive Health rvices.

ne Out-of-Pocket Maximum nount includes the Deductible nd Coinsurance.

e-Approval is recommended r all Inpatient admissions.

ot all benefit descriptions and clusions are included in this ocument. Complete benefit escriptions and exclusions are ntinued in the AultCare surance Company Medical an document which will vern.

ontact AultCare ww.aultcare.com 80-363-6360 800-344-8858



Canton Regional Chamber Health Fund 2500 A

Health Savings Account (HSA) Compatible 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	\$15,000
Family	\$5,000	\$30,000
Physician Office Visits and Telemedic	cine	
Illness/Injury	100%	80% RBP
Behavioral Health	100%	80% RBP
Prescription Drugs (Follow		
Premium Managed Formulary)	100%	
Preventive Health Services		
As defined by		1
the Affordable Care Act.		
See www.healthcare.gov for	100%	50% RBP
additional information.		
Maternity Care	100%	80% RBP
		0070 N.D.
Inpatient Hospital Services	100%	80% RBP
Emergency Services	100%	100% RBP
Urgent Care	100%	100% RBP
Diagnostic Services	4000/	000/ 555
(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 <u>DO 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.

Deductible is waived for Network Preventive Health Services.

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

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 continued in the AultCare Insurance Company Medical Plan document which will govern.

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