



**AultAlternative 1000/80 B  
Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
<b>Calendar Year Deductible</b>		
<i>Employee</i>	\$1,000	\$2,000
<i>Family</i>	\$2,000	\$4,000
<b>Medical Plan Out-of-Pocket Maximum</b>		
<i>Employee</i>	\$2,000	\$4,000
<i>Family</i>	\$4,000	\$8,000
<b>Physician Office Visits and Telemedicine</b>		
<i>For Illness</i>	\$25 Copayment	60% UCR
<i>For Injury</i>	\$25 Copayment	\$25 Copayment UCR
<b>Prescription Drugs</b>	See Reverse side	
<b>Preventive Health Services</b>		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% UCR
<b>Maternity Care</b>	80%	60% UCR
<b>Inpatient Hospital Services</b>	80%	60% UCR
<b>Emergency Services</b>	\$50 Copayment	\$50 Copayment UCR
<b>Diagnostic Services</b> <i>(Labs, X-rays)</i>	80%	60% UCR
<b>Outpatient Therapy Services</b>	80%	60% UCR
<b>Other Services</b> <i>Refer to Summary Plan Description</i>	80%	60% UCR
<b>Ambulance</b>	80%	80% UCR
<b>Annual Plan Maximum</b>	UNLIMITED	UNLIMITED

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

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

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

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

**Deductible is waived for Network Preventive Health Services.**

Pre-Approval is recommended for all Inpatient admissions.

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

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

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



Prescription Drugs	Retail	Mail Order (60 day supply)
<i>Tier 1 1-34 day supply</i>	\$10 Copayment or 20%, greater of	\$27 Copayment
<i>Tier 1 35-60 day supply</i>	\$27 Copayment	
<i>Tier 2</i>	\$20 Copayment or 30%, greater of	\$55 Copayment
<i>Tier 3</i>	\$45 Copayment or 50%, greater of	\$110 Copayment
<b>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.</b>		
<i>Tier 4</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<i>Tier 5</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<p><i>A thirty four (34) day supply is available at the retail pharmacy</i>  <i>A sixty (60) day supply is available at the retail pharmacy for Tier 1</i>  <i>A sixty (60) day supply may be obtained through the mail order program</i></p>		

#### 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.

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



**Aulternative 1000/100 B  
Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
<b>Calendar Year Deductible</b>		
<i>Employee</i>	\$1,000	\$2,000
<i>Family</i>	\$2,000	\$4,000
<b>Medical Plan Out-of-Pocket Maximum</b>		
<i>Employee</i>	\$2,000	\$4,000
<i>Family</i>	\$4,000	\$8,000
<b>Physician Office Visits and Telemedicine</b>		
<i>For Illness</i>	\$25 Copayment	80% UCR
<i>For Injury</i>	\$25 Copayment	\$25 Copayment UCR
<b>Prescription Drugs</b>	See Reverse side	
<b>Preventive Health Services</b>		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% UCR
<b>Maternity Care</b>	100%	80% UCR
<b>Inpatient Hospital Services</b>	100%	80% UCR
<b>Emergency Services</b>	\$50 Copayment	\$50 Copayment UCR
<b>Diagnostic Services</b> <i>(Labs, X-rays)</i>	100%	80% UCR
<b>Outpatient Therapy Services</b>	100%	80% UCR
<b>Other Services</b> <i>Refer to Summary Plan Description</i>	100%	80% UCR
<b>Ambulance</b>	100%	100% UCR
<b>Annual Plan Maximum</b>	UNLIMITED	UNLIMITED

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

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

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

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

**Deductible is waived for Network Preventive Health Services.**

Pre-Approval is recommended for all Inpatient admissions.

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

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

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



Prescription Drugs	Retail	Mail Order (60 day supply)
<i>Tier 1 1-34 day supply</i>	\$10 Copayment or 20%, greater of	\$27 Copayment
<i>Tier 1 35-60 day supply</i>	\$27 Copayment	
<i>Tier 2</i>	\$20 Copayment or 30%, greater of	\$55 Copayment
<i>Tier 3</i>	\$45 Copayment or 50%, greater of	\$110 Copayment
<b>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.</b>		
<i>Tier 4</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<i>Tier 5</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<p><i>A thirty four (34) day supply is available at the retail pharmacy</i>  <i>A sixty (60) day supply is available at the retail pharmacy for Tier 1</i>  <i>A sixty (60) day supply may be obtained through the mail order program</i></p>		

#### 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.

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



**Alternative 1500/90 B  
Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
<b>Calendar Year Deductible</b>		
<i>Employee</i>	\$1,500	\$3,000
<i>Family</i>	\$3,000	\$6,000
<b>Medical Plan Out-of-Pocket Maximum</b>		
<i>Employee</i>	\$2,500	\$6,000
<i>Family</i>	\$5,000	\$12,000
<b>Physician Office Visits and Telemedicine</b>		
<i>For Illness</i>	\$25 Copayment	70% UCR
<i>For Injury</i>	\$25 Copayment	\$25 Copayment UCR
<b>Prescription Drugs</b>	See Reverse side	
<b>Preventive Health Services</b>		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% UCR
<b>Maternity Care</b>	90%	70% UCR
<b>Inpatient Hospital Services</b>	90%	70% UCR
<b>Emergency Services</b>	\$150 Copayment	\$150 Copayment UCR
<b>Diagnostic Services</b> <i>(Labs, X-rays)</i>	90%	70% UCR
<b>Outpatient Therapy Services</b>	90%	70% UCR
<b>Other Services</b> <i>Refer to Summary Plan Description</i>	90%	70% UCR
<b>Ambulance</b>	90%	90% UCR
<b>Annual Plan Maximum</b>	UNLIMITED	UNLIMITED

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

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

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

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

**Deductible is waived for Network Preventive Health Services.**

Pre-Approval is recommended for all Inpatient admissions.

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

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

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



<b>Prescription Drugs</b>	<b>Retail</b>	<b>Mail Order (60 day supply)</b>
<i>Tier 1 1-34 day supply</i>	\$10 Copayment or 20%, greater of	\$27 Copayment
<i>Tier 1 35-60 day supply</i>	\$27 Copayment	
<i>Tier 2</i>	\$20 Copayment or 30%, greater of	\$55 Copayment
<i>Tier 3</i>	\$45 Copayment or 50%, greater of	\$110 Copayment
<b>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.</b>		
<i>Tier 4</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<i>Tier 5</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<p><i>A thirty four (34) day supply is available at the retail pharmacy</i>  <i>A sixty (60) day supply is available at the retail pharmacy for Tier 1</i>  <i>A sixty (60) day supply may be obtained through the mail order program</i></p>		

#### **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.

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



**AultCare**  
**Aulternative 1500/100 B**  
**Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
<b>Calendar Year Deductible</b>		
<i>Employee</i>	\$1,500	\$3,000
<i>Family</i>	\$3,000	\$6,000
<b>Medical Plan Out-of-Pocket Maximum</b>		
<i>Employee</i>	\$1,500	\$6,000
<i>Family</i>	\$3,000	\$12,000
<b>Physician Office Visits and Telemedicine</b>		
<i>For Illness</i>	\$25 Copayment	80% UCR
<i>For Injury</i>	\$25 Copayment	\$25 Copayment UCR
<b>Prescription Drugs</b>	See Reverse side	
<b>Preventive Health Services</b>		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% UCR
<b>Maternity Care</b>	100%	80% UCR
<b>Inpatient Hospital Services</b>	100%	80% UCR
<b>Emergency Services</b>	\$150 Copayment	\$150 Copayment UCR
<b>Urgent Care</b>	\$50 Copayment	\$50 Copayment UCR
<b>Diagnostic Services</b> <i>(Labs, X-rays)</i>	100%	80% UCR
<b>Outpatient Therapy Services</b>	100%	80% UCR
<b>Other Services</b> <i>Refer to Summary Plan Description</i>	100%	80% UCR
<b>Ambulance</b>	100%	100% UCR
<b>Annual Plan Maximum</b>	UNLIMITED	UNLIMITED

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

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

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

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

**Deductible is waived for Network Preventive Health Services.**

Pre-Approval is recommended for all Inpatient admissions.

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

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

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



Prescription Drugs	Retail	Mail Order (60 day supply)
<i>Tier 1 1-34 day supply</i>	\$10 Copayment or 20%, greater of	\$27 Copayment
<i>Tier 1 35-60 day supply</i>	\$27 Copayment	
<i>Tier 2</i>	\$20 Copayment or 30%, greater of	\$55 Copayment
<i>Tier 3</i>	\$45 Copayment or 50%, greater of	\$110 Copayment
<b>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.</b>		
<i>Tier 4</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<i>Tier 5</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<p><i>A thirty four (34) day supply is available at the retail pharmacy</i>  <i>A sixty (60) day supply is available at the retail pharmacy for Tier 1</i>  <i>A sixty (60) day supply may be obtained through the mail order program</i></p>		

#### 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.

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





**Alternative 2000/80 B**  
**Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
<b>Calendar Year Deductible</b>		
<i>Employee</i>	\$2,000	\$4,000
<i>Family</i>	\$4,000	\$8,000
<b>Medical Plan Out-of-Pocket Maximum</b>		
<i>Employee</i>	\$4,000	\$8,000
<i>Family</i>	\$8,000	\$16,000
<b>Physician Office Visits and Telemedicine</b>		
<i>For Illness</i>	\$25 Copayment	60% UCR
<i>For Injury</i>	\$25 Copayment	\$25 Copayment UCR
<b>Prescription Drugs</b>	See Reverse side	
<b>Preventive Health Services</b>		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% UCR
<b>Maternity Care</b>	80%	60% UCR
<b>Inpatient Hospital Services</b>	80%	60% UCR
<b>Emergency Services</b>	\$50 Copayment	\$50 Copayment UCR
<b>Diagnostic Services</b> <i>(Labs, X-rays)</i>	80%	60% UCR
<b>Outpatient Therapy Services</b>	80%	60% UCR
<b>Other Services</b> <i>Refer to Summary Plan Description</i>	80%	60% UCR
<b>Ambulance</b>	80%	80% UCR
<b>Annual Plan Maximum</b>	UNLIMITED	UNLIMITED

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

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

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

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

**Deductible is waived for Network Preventive Health Services.**

Pre-Approval is recommended for all Inpatient admissions.

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

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

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



<b>Prescription Drugs</b>	<b>Retail</b>	<b>Mail Order (60 day supply)</b>
<i>Tier 1 1-34 day supply</i>	\$10 Copayment or 20%, greater of	\$27 Copayment
<i>Tier 1 35-60 day supply</i>	\$27 Copayment	
<i>Tier 2</i>	\$20 Copayment or 30%, greater of	\$55 Copayment
<i>Tier 3</i>	\$45 Copayment or 50%, greater of	\$110 Copayment
<b>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.</b>		
<i>Tier 4</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<i>Tier 5</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<p><i>A thirty four (34) day supply is available at the retail pharmacy</i>  <i>A sixty (60) day supply is available at the retail pharmacy for Tier 1</i>  <i>A sixty (60) day supply may be obtained through the mail order program</i></p>		

#### **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.

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



**AultCare**  
**Alternative 2000/100 B**  
**Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
<b>Calendar Year Deductible</b>		
<i>Employee</i>	\$2,000	\$4,000
<i>Family</i>	\$4,000	\$8,000
<b>Medical Plan Out-of-Pocket Maximum</b>		
<i>Employee</i>	\$2,000	\$8,000
<i>Family</i>	\$4,000	\$16,000
<b>Physician Office Visits and Telemedicine</b>		
<i>For Illness</i>	\$25 Copayment	80% UCR
<i>For Injury</i>	\$25 Copayment	\$25 Copayment UCR
<b>Prescription Drugs</b>	See Reverse side	
<b>Preventive Health Services</b>		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% UCR
<b>Maternity Care</b>	100%	80% UCR
<b>Inpatient Hospital Services</b>	100%	80% UCR
<b>Emergency Services</b>	\$50 Copayment	\$50 Copayment UCR
<b>Diagnostic Services</b> <i>(Labs, X-rays)</i>	100%	80% UCR
<b>Outpatient Therapy Services</b>	100%	80% UCR
<b>Other Services</b> <i>Refer to Summary Plan Description</i>	100%	80% UCR
<b>Ambulance</b>	100%	100% UCR
<b>Annual Plan Maximum</b>	UNLIMITED	UNLIMITED

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

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

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

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

**Deductible is waived for Network Preventive Health Services.**

Pre-Approval is recommended for all Inpatient admissions.

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

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

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



Prescription Drugs	Retail	Mail Order (60 day supply)
<i>Tier 1 1-34 day supply</i>	\$10 Copayment or 20%, greater of	\$27 Copayment
<i>Tier 1 35-60 day supply</i>	\$27 Copayment	
<i>Tier 2</i>	\$20 Copayment or 30%, greater of	\$55 Copayment
<i>Tier 3</i>	\$45 Copayment or 50%, greater of	\$110 Copayment
<b>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.</b>		
<i>Tier 4</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<i>Tier 5</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<p><i>A thirty four (34) day supply is available at the retail pharmacy</i>  <i>A sixty (60) day supply is available at the retail pharmacy for Tier 1</i>  <i>A sixty (60) day supply may be obtained through the mail order program</i></p>		

#### 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.

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



**Alternative 2500 B**  
**Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
<b>Calendar Year Deductible</b>		
<i>Employee</i>	\$2,500	\$4,000
<i>Family</i>	\$5,000	\$8,000
<b>Medical Plan Out-of-Pocket Maximum</b>		
<i>Employee</i>	\$2,500	\$8,000
<i>Family</i>	\$5,000	\$16,000
<b>Physician Office Visits and Telemedicine</b>		
<i>For Illness</i>	\$25 Copayment	80% UCR
<i>For Injury</i>	\$25 Copayment	\$25 Copayment UCR
<b>Prescription Drugs</b>	See Reverse side	
<b>Preventive Health Services</b>		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% UCR
<b>Maternity Care</b>	100%	80% UCR
<b>Inpatient Hospital Services</b>	100%	80% UCR
<b>Emergency Services</b>	\$50 Copayment	\$50 Copayment UCR
<b>Diagnostic Services</b> <i>(Labs, X-rays)</i>	100%	80% UCR
<b>Outpatient Therapy Services</b>	100%	80% UCR
<b>Other Services</b> <i>Refer to Summary Plan Description</i>	100%	80% UCR
<b>Ambulance</b>	100%	100% UCR
<b>Annual Plan Maximum</b>	UNLIMITED	UNLIMITED

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

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

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

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

**Deductible is waived for Network Preventive Health Services.**

Pre-Approval is recommended for all Inpatient admissions.

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

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

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



Prescription Drugs	Retail	Mail Order (60 day supply)
<i>Tier 1 1-34 day supply</i>	\$10 Copayment or 20%, greater of	\$27 Copayment
<i>Tier 1 35-60 day supply</i>	\$27 Copayment	
<i>Tier 2</i>	\$20 Copayment or 30%, greater of	\$55 Copayment
<i>Tier 3</i>	\$45 Copayment or 50%, greater of	\$110 Copayment
<b>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.</b>		
<i>Tier 4</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<i>Tier 5</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<p><i>A thirty four (34) day supply is available at the retail pharmacy</i>  <i>A sixty (60) day supply is available at the retail pharmacy for Tier 1</i>  <i>A sixty (60) day supply may be obtained through the mail order program</i></p>		

#### 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.

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



**Alternative 5000 B**  
**Schedule of Health Insurance Benefits**

Medical Benefits	Network	Non-Network
<b>Calendar Year Deductible</b>		
<i>Employee</i>	\$5,000	\$7,500
<i>Family</i>	\$10,000	\$15,000
<b>Medical Plan Out-of-Pocket Maximum</b>		
<i>Employee</i>	\$5,000	\$10,000
<i>Family</i>	\$10,000	\$20,000
<b>Physician Office Visits and Telemedicine</b>		
<i>For Illness</i>	\$25 Copayment	80% UCR
<i>For Injury</i>	\$25 Copayment	\$25 Copayment UCR
<b>Prescription Drugs</b>	See Reverse side	
<b>Preventive Health Services</b>		
<i>As defined by the Affordable Care Act. See www.healthcare.gov for additional information.</i>	100%	50% UCR
<b>Maternity Care</b>	100%	80% UCR
<b>Inpatient Hospital Services</b>	100%	80% UCR
<b>Emergency Services</b>	\$50 Copayment	\$50 Copayment UCR
<b>Diagnostic Services</b> <i>(Labs, X-rays)</i>	100%	80% UCR
<b>Outpatient Therapy Services</b>	100%	80% UCR
<b>Other Services</b> <i>Refer to Summary Plan Description</i>	100%	80% UCR
<b>Ambulance</b>	100%	100% UCR
<b>Annual Plan Maximum</b>	UNLIMITED	UNLIMITED

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

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

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

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

**Deductible is waived for Network Preventive Health Services.**

Pre-Approval is recommended for all Inpatient admissions.

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

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

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



Prescription Drugs	Retail	Mail Order (60 day supply)
<i>Tier 1 1-34 day supply</i>	\$10 Copayment or 20%, greater of	\$27 Copayment
<i>Tier 1 35-60 day supply</i>	\$27 Copayment	
<i>Tier 2</i>	\$20 Copayment or 30%, greater of	\$55 Copayment
<i>Tier 3</i>	\$45 Copayment or 50%, greater of	\$110 Copayment
<b>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.</b>		
<i>Tier 4</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<i>Tier 5</i>	\$125 Copayment or 20%, greater of	\$125 Copayment or 20%, greater of
<p><i>A thirty four (34) day supply is available at the retail pharmacy</i></p> <p><i>A sixty (60) day supply is available at the retail pharmacy for Tier 1</i></p> <p><i>A sixty (60) day supply may be obtained through the mail order program</i></p>		

#### **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.

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