# Group Purchasing Plan III
# Schedule of Health Insurance Benefits

| Medical Benefits | Network | Non-Network |
|---|---|---|
| **Calendar Year Deductible** | | |
| *Employee* | $200 | $600 |
| *Family* | $400 | $1,200 |
| **Medical Plan Out-of-Pocket Maximum** | | |
| *Employee* | $700 | $2,100 |
| *Family* | $1,400 | $4,200 |
| **Prescription Drug Out-of-Pocket Maximum** *Separate from Medical* | | |
| *Employee* | $8,750 | N/A |
| *Family* | $17,500 | N/A |
| **Physician Office Visits and Telemedicine** | | |
| *Illness/Injury* | $10 Copayment | 70% RBP |
| *Behavioral Health* | $10 Copayment | 70% RBP |
| | | |
| **Prescription Drugs** | See Reverse side | |
| **Preventive Health Services** | | |
| *As defined by the Affordable Care Act. See www.healthcare.gov for additional information.* | 100% | 70% RBP |
| **Maternity Care** | 90% | 70% RBP |
| **Inpatient Hospital Services** | 90% | 70% RBP |
| **Emergency Services** | $75 Copayment | $75 Copayment RBP |
| **Urgent Care** | $50 Copayment | $50 Copayment RBP |
| **Diagnostic Services** *(Labs, X-rays)* | 90% | 70% RBP |
| **Outpatient Therapy Services** | 90% | 70% RBP |
| **Other Services** *(Refer to Summary Plan Description)* | 90% | 70% RBP |
| **Ambulance** | 80% | 80% RBP |
| **Annual Plan Maximum** | UNLIMITED | UNLIMITED |

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

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

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

**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, 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.**

**7/2023**

## This Plan follows the Premium Managed Formulary

| Prescription Drugs | Retail | Mail Order (*90 day supply)* |
|---|---|---|
| *Tier 1 -*<br>*1-34 day supply* | $10 Copayment or 20%,<br>greater of | $25 Copayment or 20%,<br>greater of |
| *Tier 1 -*<br>*35-60 day supply* | $20 Copayment or 20%,<br>greater of | |
| *Tier 2* | $30 Copayment or 30%,<br>greater of | $85 Copayment or 25%,<br>greater of ($200 max) |
| *Tier 3* | $45 Copayment or 50%,<br>greater of | $130 Copayment or 45%,<br>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%,<br>greater of | $10 Copayment or 20%,<br>greater of |
| *Tier 5* | $125 Copayment or 20%,<br>greater of | $125 Copayment or 20%,<br>greater of |
| *A thirty four (34) day supply is available at the retail pharmacy*<br>*A sixty (60) day supply is available at the retail pharmacy for Tier 1*<br>*A ninety (90) day supply may be obtained through the mail order program* | | |

**There is an Out of Pocket Maximum of $8,750 per Covered Person or $17,500 per Family.**
**Once the Out of Pocket 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

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