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	$8,500	N/A
Family	$17,000	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.

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AULTCARE

This Plan follows the Premium Managed Formulary

Prescription Drugs	Retail	Mail Order (*90 day supply*)
Tier 1 - 1-34 day supply	$10 Copayment or 20%, greater of	$25 Copayment or 20%, greater of
Tier 1 - 35-60 day supply	$20 Copayment or 20%, greater of	
Tier 2	$30 Copayment or 30%, greater of	$85 Copayment or 25%, greater of ($200 max)
Tier 3	$45 Copayment or 50%, greater of	$130 Copayment or 45%, greater of ($400 max)
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 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%, greater of	
Tier 5	$125 Copayment or 20%, greater of	

There is an Out of Pocket Maximum of $8,500 per Covered Person or $17,000 per Family.
Once the Out of Pocket Maximum is met, Prescription Copayments and Coinsurance are $0.

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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