AULTCARE

SMALL GROUP

Health Benefit Plans for Northeast Ohio

You matter.

WHAT DOES AULTCARE OFFER?

As a leader in the healthcare industry for over 37 years, AultCare continues to keep members satisfied through innovative plan designs, superior customer service, and a cost-effective high quality network.

PLANS AND COVERAGE

Our new plans at AultCare offer guaranteed coverage and no pre-existing conditions. They also include:

- Prescription Drug benefits
- $0 cost preventive care visits (in-network)
- $0 cost flu shots (in-network)
- No forms to complete for claims (in-network)
- No lifetime dollar maximum limits on covered services

With AultCare, we have many coverage levels to meet your needs:

- Individual
- Individual and Spouse
- Individual and Child(ren)
- Entire Family

CUSTOMER SERVICE

Our strengths are at your service:

- REAL people answering the phone when you call
- Calls transferred, on average, in less than 30 seconds
- Local service: 330-363-6360 (TTY: 711)
- 24/7 Nurse hotline: 1-866-422-9603
- Email access: aultcare@aultcare.com
- In-person access at: 2600 Sixth Street S.W. Canton, Ohio 44710

WEBSITE

The AultCare website is available 24/7 to give you the access and answers you need. Visit our website and explore the following features:

- Access to your healthcare coverage, member ID cards, Explanation of Benefits, coverage details, claims, & more
- Prescription Plans & Formulary
- Physician's directory with search by name, location, or specialty

You can find information about non-covered benefits, practitioner and provider availability, utilization management procedures, pharmaceutical management procedures, and privacy rights at www.aultcare.com or by calling 330-363-6360 (TTY: 711).

AULTCARE

Helping you navigate the Marketplace

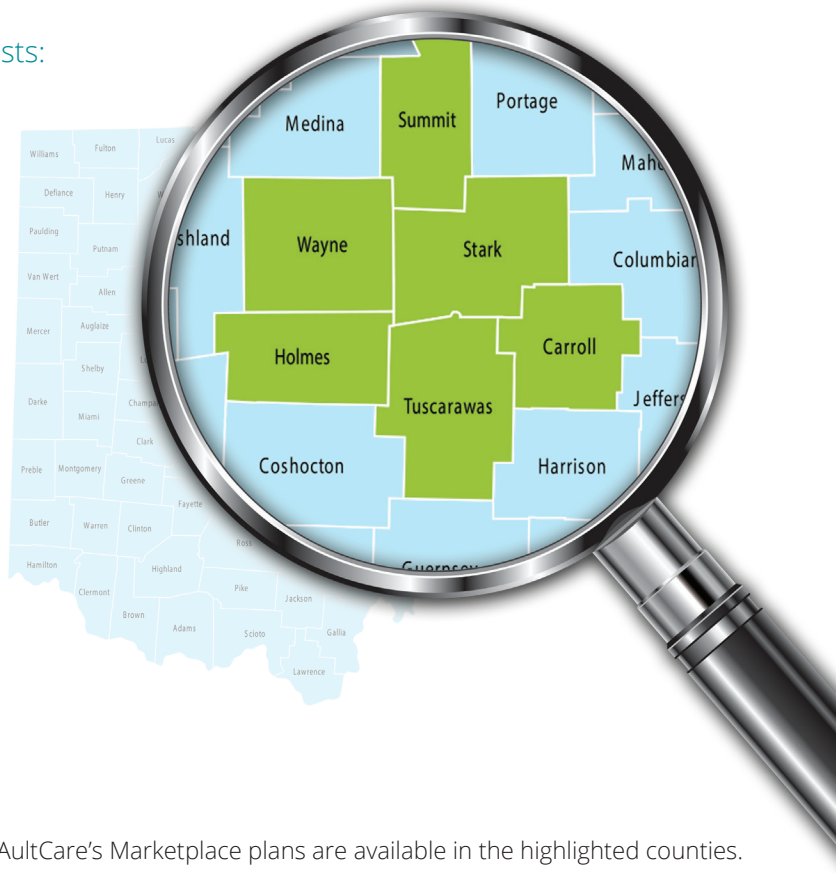
Marketplace allows Small Employers to shop for health insurance in a transparent environment that permits the employer to pick the plan that fits their needs both from a coverage and cost standpoint. Small group plans are community rated and this means rates are not affected by the health status of the employees and/or dependents.

Metal Plan	Average Health Plans Payment
Bronze	60%
Silver	70 %
Gold	80 %
Platinum	90 %

Be aware the following may affect your health plan costs:

- Age
- Family size
- Location
- Plan metal level

Dental & Vision options are available with some plans. Be sure to add those to your selections, if needed.



AultCare's Marketplace plans are available in the highlighted counties.

You've selected your plan, what does it include?

AultCare health plans include:

- Prescription coverage
- Inpatient services
- Outpatient services
- Maternity coverage
- Newborn care services
- Pediatric services
- Emergency services
- In-network preventive care services such as screenings and physicals
- Ongoing Disease Management
- Urgent care services
- Laboratory services (blood work, screenings)
- Rehabilitation services
- Substance abuse services
- Mental health coverage
- Durable medical equipment services

The National Committee for Quality Assurance (NCQA) has awarded AultCare with NCQA Health Plan Accreditation for our Commercial PPO, Commercial HMO and Marketplace PPO products. NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.

ACCREDITED NCQA HEALTH PLAN ACCREDITED — COMMERCIAL HMO

ACCREDITED NCQA HEALTH PLAN ACCREDITED — COMMERCIAL PPO

ACCREDITED NCQA HEALTH PLAN ACCREDITED — MARKETPLACE PPO

These NCQA seals represent NCQA Health Plan report card year 2022-2023.

AultCare Insurance Company Small Group Marketing Brochure

Enclosed, please find the Schedule of Benefits for this policy. This policy contains exclusions, limitations, reduction of benefits and certain items under which the policy may, be continued in force or discontinued. For costs and complete details of coverage, call or write your insurance agent or AultCare Insurance Company.

Gold 2600 2023 01January
Effective Date: 01/01/2023

GOLD 2600

MEDICAL BENEFITS	NETWORK	NON-NETWORK
Annual Plan Maximum	**UNLIMITED**	**UNLIMITED**
Annual Deductible per Individual	**$2,600**	**$7,800**
Annual Deductible per Family	**$5,200**	**$15,600**
Maximum Out of Pocket per Individual	**$2,600**	**$27,300**
Maximum Out of Pocket per Family	**$5,200**	**$54,600**
Are Deductible amounts Embedded?		No
Are Network and Non-Network Deductibles and Out of Pocket amounts integrated?		No
Are the Out of Pocket amounts Embedded?		No
Does the Maximum Out of Pocket Include the Annual Deductible?		Yes
Does the Medical Network Out of Pocket amounts include Prescription Drugs?		Yes
Inpatient Hospital		
Semi-Private Room	**100%[1]**	**80%[2]**
Surgery	**100%[1]**	**80%[2]**
Physician	**100%[1]**	**80%[2]**
Ancillary Services	**100%[1]**	**80%[2]**
Outpatient Services		
Emergency Room (Emergent)	**100%[1]**	**100%[1,7]**
Urgent Care Facility (Emergent)	**100%[1]**	**100%[1,7]**
Same Day Surgery	**100%[1]**	**80%[2]**
Nursing Care		
Home Health Care (Utilization Management approval required)	**100%[1]**	**80%[2]**
- Accumulation Type		Calendar Year
--- Visits 100		
Hospice Care (Utilization Management approval required)	**100%[1]**	**80%[2]**
- Is Bereavement Counseling covered or not covered?		**Covered**
Private Duty Nursing (Utilization Management approval required)	**100%[1]**	**80%[2]**
--- Accumulation Type		Calendar Year
--- Visits 90		
Skilled Nursing Facility (Utilization Management approval required)	**100%[1]**	**80%[2]**
- Accumulation Type		Calendar Year
--- Days 90		

Other Services

Allergy Tests	**100%[1]**	**80%[2]**
Allergy Extract	**100%[1]**	**80%[2]**
Allergy Injections	**100%[1]**	**80%[2]**
Ambulance	**100%[1]**	**100%[1,7]**
Diagnostic Testing/Laboratory/X-Ray - Office/Outpatient	**100%[1]**	**80%[2]**
Diabetic Supplies	**100%[1]**	**80%[2]**
Diabetes Education/Medical Nutrition Therapy	**100%[1]**	**80%[2]**

--- Notes:

Additional Preventive services: Preventive Services Nutritional Counseling to prevent obesity in children and to prevent cardiovascular disease in adults with cardiovascular risk factors is limited to a total of 4 visits per benefit period.

Dialysis	**100%[1]**	**80%[2]**
Durable Medical Equipment	**100%[1]**	**80%[2]**
Maternity Care - Is coverage based on services rendered?		**Yes**
Pre-Admission Testing	**100%[1]**	**80%[2]**
Second Surgical Opinion	**Based on Service**	**Based on Service**

Care in the Physician's Office

Visits for Illness	**100%[1]**	**80%[2]**
Visits for Injury	**100%[1]**	**80%[2]**
Specialist Visit for Illness	**100%[1]**	**80%[2]**
Specialist Visit for Injury	**100%[1]**	**80%[2]**
Telehealth (with a traditional provider)	**Based on Service**	**Based on Service**
Telemedicine for General Medicine (with a virtual vendor)	**100%[1]**	
Telemedicine for Dermatology (with a virtual vendor)	**100%[1]**	
Does Telemedicine include Mental Health/Substance Abuse Psychological services? (If yes, benefit is the same as a PCP office visit).		Yes

Therapy Services

Cardiac Rehab Inpatient (Phase I)	**100%[1]**	**80%[2]**
Cardiac Rehab Outpatient (Phase II)	**100%[1]**	**80%[2]**

Cardiac Rehab (Phase III) This is not a covered service:

--- Notes:

Outpatient is limited to 36 visits per calendar year.

Chemo and Radiation Therapy	**100%[1]**	**80%[2]**
Habilitative Services	**100%[1]**	**80%[2]**
This plan allows to what age?		No Limit
Speech and Language therapy and/or Occupational therapy, performed by a licensed therapists. This plan allows (visits per year of each service):		20

Clinical Therapeutic Intervention defined as therapies supported by empirical evidence, which include but are not limited to Applied Behavioral Analysis. This plan allows (hours per week): 20

Also allows Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans. :

Manipulation Therapy **100%[1]** **80%[2]**

- Accumulation Type Calendar Year

--- Manipulation Therapy 12

--- Notes:

Modalities are included with Physical Therapy and Occupational Therapy limitations.

Occupational Therapy (Illness/Injury Related) **100%[1]** **80%[2]**

- Accumulation Type Calendar Year

--- Visits 40

--- Are limitations combined with speech therapy? No

--- Are limitations combined with physical therapy? Yes

--- Notes:

Outpatient and office Physical/Occupational therapy (including chiropractic modalities) is limited to 40 visits combined per calendar year.

Physical Therapy (Illness/Injury Related) **100%[1]** **80%[2]**

- Accumulation Type Calendar Year

--- Visits 40

--- Are limitations combined with speech therapy? No

--- Are limitations combined with occupational therapy? Yes

--- Notes:

Outpatient and office Physical/Occupational therapy (including chiropractic modalities) is limited to 40 visits combined per calendar year.

Rehabilitative Therapy **100%[1]** **80%[2]**

--- Days 60

--- Notes:

Physical Rehabilitation Facilities include coverage for Day Rehab Program services subject to combined 60 day limit with inpatient services.

Respiratory Therapy **100%[1]** **80%[2]**

--- Notes:

PULMONARY REHABILITATION: Limited to 20 visits per calendar year; When rendered in the home, Home Care Services limits apply. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here. Includes outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation

in the acute Inpatient rehabilitation setting is not a Covered Service.

Speech Therapy (Illness/Injury Related)		**100%[1]**	**80%[2]**
- Accumulation Type			Calendar Year
--- Visits	20		
--- Are limitations combined with physical therapy?			No
--- Are limitations combined with occupational therapy?			No
--- Notes	Outpatient and office speech therapy is limited to 20 visits combined per calendar year.		

Preventive Care

Well Child Care	**100%**	**80%[2]**
Are immunizations included in well child care?		Yes
--- Age limitation (through age)		20

--- Notes:

Covered Services for routine physical include, but are not limited to, the Physician's office visit charge and related tests, x-rays, routine cancer screenings, routine mammograms, routine gynecological exam, routine pap, age and gender appropriate screening, routine prostate screening, lab work and immunizations. These Network services will be paid at 100% unless the routine physical is not defined as a Preventive Health Service.

Routine Eye Exam	**100%**	**80%[2]**

--- Notes:

ROUTINE VISION CARE (PROFESSIONALLY INDICATED REFRACTION AND DILATION) IS ONLY COVERED TO AGE 19 *** NOT COVERED FOR ADULTS* ADDITIONAL BENEFIT LEVEL: Network: 100% after Network deductible; Non Network 80% UCR after Non Network deductible. // Additional Benefits include: 1 set of glasses per year ; 1 prescription of lenses per year (coverage includes: Single vision, or conventional bifocal, or trifocal, or lenticular lenses. Lenses may be glass, plastic, or polycarbonate with scratch resistant and/or ultraviolet protective coating.) In lieu of glasses, 1 prescription of contacts are covered, including fitting/evaluation/follow-up care.

Routine Physical Exam	**100%**	**80%[2]**

--- Notes:

Covered Services for a routine physical include, but are not limited to, the Physician's office visit charge and related tests, x-rays, routine cancer screenings, routine mammograms, routine gynecological exam, routine pap, age and gender appropriate screening, routine prostate screening, lab work and immunizations. These Network services will be paid at 100% unless the routine physical is not defined as a Preventive Health Service.

Routine Prostate/PSA Screening	**100%**	**80%[2]**
Routine Gynecological Exam	**100%**	**80%[2]**
Routine Pap Test/Smear	**100%**	**80%[2]**
Routine Immunizations	**100%**	**80%[2]**
Routine Mammograms	**100%**	**80%[2,4]**

Prescription Drugs

Benefit level	**100%[1]**	**100%[1]**

Mental Health and / or Substance Abuse

In lieu of an Inpatient stay, Outpatient care (including a partial hospital or intensive outpatient program) will be paid for as any other Outpatient service.	**100%[1,3]**	**80%[2,3]**

--- Notes:

The Mental Health Parity and Addiction Equity Act of 2008: Mental Health/Addiction Inpatient coverage will be paid the same as any other Inpatient stay. Refer to Inpatient Hospital for benefit level. Includes Residential Treatment facilities.

Mental Health/Substance Abuse Psychotherapy - Office Visit will be considered same as PCP office visit.

Pediatric Dental Services

Benefit level	100%	80%[2]

• Periodic/Limited/Comprehensive /Comprehensive Periodontal Evaluations- 1 every 6 months.:

• Bitewings - single film, two films, four films, vertical (7-8 films); 1 set every 6 months.

• Panoramic film- 1 every 60 months.

• Prophylaxis- 1 every 6 months.

• Topical application of fluoride (excluding prophylaxis)- limited to 2 every 12 months.

• Sealant - per tooth - unrestored permanent molars - less than age 19. 1 sealant per tooth every 36 months.

• Space maintainer – fixed – unilateral/bilateral/removable- unilateral/bilateral - Limited to children under age 19:

Benefit level	100%[1]	80%[2]

• Orthodontia - Medically Necessary; services before 1/1/17 subject to a 24 month waiting period; services after 1/1/17 a waiting period does not apply.:

• Amalgam - 1 or more surfaces, primary or permanent:

• Inlay/Onlay/Crown:

• Root Canal:

Additional

Precertification may be required.

This information is intended to provide a summary of benefits. Not all benefit descriptions and exclusions are included in this summary.

---

[1] INDIVIDUAL COVERAGE: A per Covered Person Deductible of $2,600 per Calendar Year is applied first before any Covered Services are paid to Network Providers, and designated Covered Services to Non-Network Providers. Deductible and Coinsurance are subject to an annual Out-of-Pocket Maximum of $2,600 per Covered Person. Once you have met this maximum, the Plan begins to pay medical Covered Services at 100%. FAMILY COVERAGE: A Family Deductible of $5,200 per Calendar Year is applied first before any Covered Services are paid to Network Providers, and designated Covered Services to Non-Network Providers. Deductible and Coinsurance are subject to an annual Out-of-Pocket Maximum of $5,200 per Family. Once You have met this maximum, the Plan begins to pay medical and prescription Covered Services at 100%.

[2]INDIVIDUAL COVERAGE: A per Covered Person Deductible of $7,800 per Calendar Year is applied first before any Covered Services are paid to Non-Network Providers. Payments to Non-Network Providers for Covered Services are based on Reference Based Pricing criteria (RBP). Deductible and Coinsurance are subject to an annual Out-of-Pocket Maximum of $27,300 per Covered Person. Once you have met this maximum, the Plan begins to pay medical Covered Services at 100% of RBP. FAMILY COVERAGE: A Family Deductible of $15,600 per Calendar Year is applied first before any Covered Services are paid to Non-Network Providers. Payments to Non-Network Providers for Covered Services are based on Reference Based Pricing criteria (RBP). Deductible and Coinsurance $54,600 per Family. Once You have met this maximum, the Plan begins to pay medical Covered Services at 100% RBP.

[3]Covered Services are paid in accordance with Mental Health Parity and Addiction Equity Act of 2008, which prohibits discrimination in the coverage for diagnosis, care, and treatment of Mental Health and/or Substance Abuse.

[4]Your Copayment and/or Coinsurance plus the Plan payment to the provider and/or facility constitutes full payment for a screening mammogram.

[5]Preventive Health Services are the recommended preventive services required to be covered without cost sharing under federal law.

[6]THIS PLAN IS FOR USE WITH A HEALTH SAVINGS ACCOUNT (HSA COMPATIBLE).

[7]Payments to Non-Network Providers for Covered Services are based on Reference Based Pricing criteria (RBP). Charges for Non-Network Provider Covered Services that exceed the RBP amount may be Your responsibility.

[8]DEDUCTIBLES AND OUT-OF-POCKETS ARE UNEMBEDDED. If you have other family members on this plan, the overall family deductible must be met before the plan begins to pay. Also, the overall family out-of-pocket limit must be met before the plan will pay covered services at 100%.