

## 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



- o 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
- o 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



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

- o Access to your healthcare coverage, member ID cards, Explanation of Benefits, coverage details, claims, & more
- o Prescription Plans & Formulary
- o 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).





## 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:

- o Age
- o 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
- o In-network preventive care services such as screenings and physicals
- Ongoing Disease Management
- Urgent care services
- Laboratory services (blood work, screenings)
- o Rehabilitation services
- Substance abuse services
- Mental health coverage
- o 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.









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.

Silver 4300 2023 01January Effective Date: 01/01/2023

## **SILVER 4300**

Annual Plan Maximum Annual Deductible per Individual Annual Deductible per Family Assimum Out of Pocket per Individual Assimum Out of Pocket per Family Are Deductible amounts Embedded? Are Network and Non-Network Deductibles and Out of Pocket amounts integree the Out of Pocket amounts Embedded? Are the Out of Pocket amounts Embedded? Are the Maximum Out of Pocket Include the Annual Deductible? Are the Medical Network Out of Pocket amounts include Prescription Drug Inpatient Hospital  Bemi-Private Room  Burgery  Bysician  Bricklary Services  Outpatient Services  Mergency Room (Emergent)  Brigent Care Facility (Emergent)  Copayment  Brigent Care Facility (Emergent)  Copayment  Brigent Care (Utilization Management approval required)  Accumulation Type		NON-NETWORI UNLIMITED \$12,900 \$25,800 \$27,300 \$54,600 Yes No Yes Yes Yes Yes 50% <sup>2</sup> 50% <sup>2</sup> 50% <sup>2</sup> 50% <sup>2</sup>
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Nursing Care  lome Health Care (Utilization Management approval required)  Accumulation Type	100%	100% <sup>7</sup>
Nursing Care  Iome Health Care (Utilization Management approval required)  Accumulation Type	\$75	\$75
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Iome Health Care (Utilization Management approval required) Accumulation Type		
	70% <sup>1</sup>	50% <sup>2</sup>
	Cale	endar Year
Visits 100		
ospice Care (Utilization Management approval required)	<b>70</b> % <sup>1</sup>	50% <sup>2</sup>
Is Bereavement Counseling covered or not covered?	c	Covered
rivate Duty Nursing (Utilization Management approval required)	<b>70</b> % <sup>1</sup>	50% <sup>2</sup>
Accumulation Type	Cale	endar Year
Visits 90		
killed Nursing Facility (Utilization Management approval required)		50% <sup>2</sup>
Accumulation Type	70% <sup>1</sup>	
Iospice Care (Utilization Management approval required) Is Bereavement Counseling covered or not covered? rivate Duty Nursing (Utilization Management approval required) Accumulation Type Visits 90 killed Nursing Facility (Utilization Management approval required)	70% <sup>1</sup> C 70% <sup>1</sup>	<b>50%<sup>2</sup></b> C <b>overed</b> <b>50%<sup>2</sup></b> endar Year

Days 90		
Other Services	70% <sup>1</sup>	50% <sup>2</sup>
Allergy Tests	70% 70% <sup>1</sup>	50% 50% <sup>2</sup>
Allergy Extract		
Allergy Injections	70% <sup>1</sup>	50% <sup>2</sup>
Ambulance	<b>70%</b> <sup>1</sup>	70% <sup>1,7</sup>
Diagnostic Testing/Laboratory/X-Ray - Office/Outpatient	70% <sup>1</sup>	50% <sup>2</sup>
Diabetic Supplies	70% <sup>1</sup>	50% <sup>2</sup>
Diabetes Education/Medical Nutrition Therapy	70% <sup>1</sup>	50% <sup>2</sup>
Notes:		
Additional Preventive services: Preventive Services Nutritional Counseling to prev	ent obesity in childr	en and to preven
cardiovascular disease in adults with cardiovascular risk factors is limited	-	· ·
Dialysis	70% <sup>1</sup>	50% <sup>2</sup>
Durable Medical Equipment	70% <sup>1</sup>	50% <sup>2</sup>
Maternity Care - Is coverage based on services rendered?		es
Pre-Admission Testing	<b>70</b> % <sup>1</sup>	50% <sup>2</sup>
Second Surgical Opinion	<b>Based on Service</b>	Based on Service
Care in the Physician's Office		
Visits for Illness	100%	50% <sup>2</sup>
- Copayment	\$40	
Visits for Injury	100%	50% <sup>2</sup>
Copayment	\$40	
Specialist Visit for Illness	100%	50% <sup>2</sup>
- Copayment	\$60	
Specialist Visit for Injury	100%	50% <sup>2</sup>
Copayment	\$60	
Telehealth (with a traditional provider)	Based on Service	Based on Servic
Telemedicine for General Medicine (with a virtual vendor)	100%	
Copayment	\$40	
Telemedicine for Dermatology (with a virtual vendor)	100%	
- Copayment	\$60	
Does Telemedicine include Mental Health/Substance Abuse Psychological services?		
(If yes, benefit is the same as a PCP office visit).	Y	es
Therapy Services		
Cardiac Rehab Inpatient (Phase I)	70% <sup>1</sup>	50% <sup>2</sup>
Cardiac Renab Inpatient (Phase II)	70% 70% <sup>1</sup>	50%
	411/0	JU /0

Notes:		
Outpatient is	limited to	36 visits per calendar year.
Chemo and Radiation Therapy	70% <sup>1</sup>	50% <sup>2</sup>
Habilitative Services	70% <sup>1</sup>	50% <sup>2</sup>
This plan allows to what age?		No Limit
Speech and Language therapy and/or Occupational therapy, performed by a licensed		20
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		20
allows (hours per week):		
Also allows Mental/Behavioral Health Outpatient Services performed by a licensed Ps	ychologist,	, Psychiatrist, or Physician
to provide consultation, assessment, development and oversight of treatment plans.		
Manipulation Therapy	70% <sup>1</sup>	50% <sup>2</sup>
- Accumulation Type		Calendar Year
Manipulation		
Therapy		
Notes:		
Modalities are included with Physical Therapy a	and Occup	ational Therapy limitations.
Occupational Therapy (Illness/Injury Related)	70% <sup>1</sup>	50% <sup>2</sup>
- 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 moda	alities) is li	mited to 40 visits combined
	·	per calendar year.
Physical Therapy (Illness/Injury Related)	70% <sup>1</sup>	50% <sup>2</sup>
- 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 moda	alities) is li	mited to 40 visits combined
		per calendar year.
Rehabilitative Therapy	70% <sup>1</sup>	50% <sup>2</sup>
- Accumulation Type		Calendar Year
Days 60		
Notes:		
Physical Rehabilitation Facilities include coverage for Day Rehab Program services	subject to	combined 60 day limit with
,	,	

inpatient services.

### **Respiratory Therapy**

70%<sup>1</sup>

50%<sup>2</sup>

--- 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)	70% <sup>1</sup>	50% <sup>2</sup>
- Accumulation	Гуре		Calendar Year
Visits	20		
Are limitations combined with physical therapy?			No
Are limitation	s combined with occupational therapy?		No
Nata	Outpatient and office speech therapy is limited to 20 visits		
Notes	combined per calendar year.		

#### **Preventive Care**

Well Child Care	100%	50% <sup>2</sup>
Are immunizations included in well child care?		Yes
Age limitation (through age)		20

--- Notes:

Covered Services for Well Child Care include, but are not limited to, the Physician's office visit charge and related tests, lab work and immunizations. These Network services will be paid at 100% unless the Well Child Care is not defined as a Preventive Health Service.

Routine Eye Exam 100% 50%<sup>2</sup>

--- Notes:

\*\*\*ROUTINE VISION CARE (PROFESSIONALLY INDICATED REFRACTION AND DILATION) IS ONLY COVERED TO AGE 19 \*\*\*
NOT COVERED FOR ADULTS\*\*\*\* ADDITIONAL BENEFIT LEVEL: Network: 70% after Network deductible; Non Network 50%
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% 50%<sup>2</sup>

--- 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%	50% <sup>2</sup>
Routine Gynecological Exam	100%	50% <sup>2</sup>
Routine Pap Test/Smear	100%	50% <sup>2</sup>
Routine Immunizations	100%	50% <sup>2</sup>
Routine Mammograms	100%	50% <sup>2,4</sup>

### **Prescription Drugs**

#### Benefits:

Retail (34 day supply) Tier 1 Zero cost share Preventive - \$0 copayment, Tier 2 \$10 or 20% whichever is greater, Tier 3 \$20 or 30% whichever is greater, Tier 4 \$45 or 40% whichever is greater, A 60 day supply of preferred generic medication may be obtained at the retail pharmacy for \$30.00 or 20%, whichever is greater. \*\*\* Mail Order (90 day supply) Tier 1 Zero cost share Preventive - \$0 copayment, Tier 2 \$30 or 20%, whichever is greater, Tier 3 \$55 or 25%, whichever is greater, Tier 4 \$125 or 35%, whichever is greater, \*\*\*Specialty Meds - (30 day supply) - must be filled through AultCare contracted specialty pharmacy network. Tier 5 \$10 or 20%, whichever is greater, Tier 6 \$50 or 50%, whichever is greater.

Notes:

Copayment after your plan's medical out of pocket maximum is reached is \$0.

50%<sup>2,3</sup>

### 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.

--- 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% 50%<sup>2</sup>

- 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
- Panoramic film- 1 every 60 months.
- Prophylaxis- 1 every 6 months.
- Topical application of fluoride (excluding prophylaxis)- limited to 2 every 12
- 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 70%<sup>1</sup> 50%<sup>2</sup>
- 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.

- <sup>1</sup>A Calendar Year Deductible of \$4,300 per Covered Person / \$8,600 per Family is applied first before any Covered Services are paid to Network Providers, and designated Covered Services to Non-Network Providers. The Deductible, Copayments and Coinsurance are subject to an Out-of-Pocket Maximum of \$9,100 per Covered Person / \$18,200 per Family. Once you have met this maximum, the Plan begins to pay medical and prescription Covered Services at 100%.
- <sup>2</sup>A Calendar Year Deductible of \$12,900 per Covered Person / \$25,800 per Family is applied first before 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 Out-of-Pocket Maximum of \$27,300 per Covered Person / \$54,600 per Family. Once you have met this maximum, the Plan begins to pay medical Covered Services at 100% RBP.
- <sup>3</sup>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.
- <sup>4</sup>Your Copayment and/or Coinsurance plus the Plan payment to the provider and/or facility constitutes full payment for a screening mammogram.
- <sup>5</sup> Preventive Health Services are the recommended preventive services required to be covered without cost sharing under federal law.
- <sup>6</sup> DEDUCTIBLES AND OUT-OF-POCKETS ARE EMBEDDED. Each member of a family is looked upon as an individual in regard to the deductible and out-of-pocket. Once a member reaches the single deductible, co-insurance will apply for that member. Once a member reaches the single out-of-pocket, no co-insurance will apply for that member.
- <sup>7</sup> 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.

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