Preferred Provider Organizations (PPO)

Schedule of Benefits

Overall Lifetime Maximum Benefits..... Unlimited

Calendar Year Deductible Amount

	In Network	Out of Network
Individual	$100.00	$200.00
Family	$200.00	$400.00

Calendar Year Out of Pocket Amount

	In Network	Out of Network
Individual	$ 500.00	$1,000.00
Family	$1,000.00	$2,000.00

Co-payment (after the deductible is satisfied) (p.19).....	90%	80%
PREVENTIVE CARE		
Routine Physical Exam	100% up to $200 per calendar year	Not Covered
Routine GYN/Pap Exam ..... (one per calendar year)	100%	Not Covered
Routine Mammography..... (one per calendar year)	100%	80% UCR**
Prostate Screening	100%	80% UCR**
Well Baby Care ..... (including immunizations up to 9 years of age)	100% (up to $500 per calendar year)	80% UCR**
PHYSICIANS OFFICE		
Allergy Testing/Injections	90%	80% UCR**
Visits for Illness	90%	80% UCR**
Emergency Care	90%	80% UCR**
Minor Surgery	90%	80% UCR**
Diagnostic Testing.....	90%	80% UCR**

	In Network	Out of Network
Speech/Occupational..... Therapy (illness/injury related)	90%	80% UCR**
Physician/Rehabilitative ..... Therapy (illness/injury related)	90%	80% UCR**
Respiratory Therapy	90%	80% UCR**
AFFILIATES		
Chiropractors	90%	80% UCR**
Podiatrists	90%	80% UCR**
MENTAL HEALTH		
Outpatient Psychotherapy.....	90% (up to 30 visits per year)	80% UCR** (up to 15 visits per year)
ALCOHOL/SUBSTANCE ABUSE		
Outpatient Psychotherapy.....	90% (up to 30 visits per calendar year)	80% UCR** (up to 15 visits per year)
MENTAL HEALTH/ALCOHOL/ SUBSTANCE ABUSE		
Inpatient Care	90% (up to 45 days per calendar year)	80% UCR** (up to 31 days per calendar year)

****The level of benefits payable under these Plans depends upon whether you choose to obtain medical care from an In-Network or Out-of-Network Provider. The plan encourages you to utilize Network Providers in order to receive the highest level of benefits payable. Network Providers will not hold you responsible for amounts exceeding the negotiated amounts.**

Dental Expense Benefits

Calendar Year Deductible Amount
Individual (p.27) $25.00
Family (p.27) $75.00

Co-payment (After Deductible Amount is Satisfied)
**Preventative and Diagnostic Services (p.28) .....100% of R & C
Basic Restorative Services (p.28) ..... 80% of R & C
Major Restorative Services (p.29) ..... 80% of R & C
**Orthodontic Services (p.30) ..... 60% of R & C

****The Dental Deductible amount is waived for Preventive and Diagnostic Services and Orthodontic Services**

Overall Calendar Year
Maximum Benefit (p.27) ..... $2,500.00 per person

Orthodontic Lifetime
Maximum Benefit (p.27) ..... $1,200.00 per person

Section III

Prescription Drug Expense Coverage

Your prescription drug benefit is administered by Caremark. This program enables you to purchase prescription drugs at a **Retail** Pharmacy or through Caremark's **Mail Service** Pharmacy. In order to ensure that your claims are processed quickly and accurately we advise the following steps be taken when filling your prescriptions.

1. Have your doctor write a prescription for up to a 34-day supply;
2. Take your prescription to a Caremark Participating Pharmacy:
   - Present your healthcare card with the Caremark sticker attached. If you have more than one insurance plan, please follow the guidelines for Coordination of Benefits listed on page 33.
   - Verify that the pharmacy has accurate information about you and your covered dependents, including birthdate and sex.
   - Pay the required 20% for each generic or brand prescription. (The Deductible requirement is waived if you use the Caremark System)
   - There is no need to file your 20% co-payment with the Insurance Company. This information is sent by tape to your claims payor on a weekly basis and if you have met your yearly out of pocket expense, it will be reimbursed to you.

*The Caremark program is available to the employee and any dependents who are "primary" under the employee's coverage.

For definition of "primary" see (page 33) Coordination of Benefits.

Caremark's **Mail Services** program is a convenient and cost-effective way for you to order up to a **90** day supply of maintenance or long-term medication. Follow the steps listed below to ensure a quick and easy ordering process.

1. For new maintenance medications, ask your doctor to write two prescriptions:
   **one for up to a 90 day supply plus refills to be ordered through the Mail Service Program.
   **the other, to be filled immediately at a Caremark participating pharmacy for use until YOU receive your prescription order.
2. Complete a Mail Service Patient Profile form and send it to Caremark along with your prescription(s) and the appropriate payment for each prescription. Be sure to include the **original** prescription.
3. Pay the required 20% copayment for each generic or brand prescription. You may make payment by check, money order or credit card.
4. Your prescription should be received within 14 days of Caremark's receipt of your order.
5. You may get refills by using the touch-tone phone toll free number at **1-888-202-1654.** This line is available **24** hours a day and is automated for your convenience.

When using a pharmacy outside of the Caremark Network, you will be required to pay **100%** of the prescription price. You must then submit the claim to your claims administrator for reimbursement under the medical plan.

For subscribers with Traditional Medical Mutual or SuperMed Plus who have **dual coverage** through the **Stark County Schools**, please follow the instructions listed below in obtaining benefits.

1. **Always** present the insurance card at the pharmacy for the employee whose coverage is primary.
2. **Pay** the **20%** co-payment required.
3 **Submit** this receipt for the 20% along with a claim form complete with the **secondary** subscribers social security number and claim information. Once your deductible is satisfied you will receive this **20%** back in full.

The coordination of prescription drug benefits for AultCare and will be handled by AultCare Claims Administration automatically, therefore; claim filing for secondary reimbursement is not required.

Non-Covered Services

- Over the Counter drugs or supplies
- Anorexiants (diet pills)
- Medical devices or supplies
- Contraceptive Devices
- Rogaine
- Retin A over age 26
- Growth Hormones
- Cosmetic
- Diabetic Supplies
- Non insulin needles and syringes
- Biotech Drugs (Unless eligible for and purchased through Caremark Therapeutic Drug Services)

Caremark Therapeutic Drug Services

Biotech drugs may be eligible for coverage through **Caremark Therapeutic Drug Services.** This mail order program specifically handles low incident high cost prescription drugs. To see if prescriptions you are currently using are eligible for coverage, please contact **Caremark Therapeutic Drug Services at 1-800-237-2767.**