CITY OF CANTON

EMPLOYEE DENTAL & VISION PLAN DOCUMENT

EFFECTIVE DATE
02/01/2021

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PLAN SPECIFICATIONS

Employer	City of Canton
Plan Administrator, Plan Sponsor and Named Fiduciary	City of Canton 218 Cleveland Ave. SW Canton, OH 44702 Phone: 330-438-4136
Agent for Legal Service	City of Canton
Plan	City of Canton Employee Dental & Vision Plan
Type of Plan	Self-Funded Dental & Vision Plan
Administration	Self-Administered by the Employer: The Employer has appointed a Third Party Administrator to handle the day to day operation of the Plan.
Third Party Administrator	AultCare PO Box 6910 Canton, OH 44706 Phone: 330-363-6360 TOLL FREE: 1-800-344-8858 TTY LINE: 330-363-2393 / 1-866-633-4752
Funding	Self-Funded with Employer and Employee Contributions <u>Employer Contributions</u> The Employer makes contributions, as needed, to pay benefits from its general assets and purchase reinsurance as reimbursement for catastrophic claims <u>Employee Contributions</u> Established as required, from time to time, by the Employer
Plan Participants	Employees of City of Canton as defined herein
Original Effective Date	February 1, 2002
Effective Date of Amended Plan	July 1, 2020
Plan Year	February 1st through January 31st
Group Number	21865
Employer Identification Number	34-6000504
Plan Number	501

SCHEDULE OF DENTAL BENEFITS

THE DENTAL EXPENSE BENEFIT PROVIDES PAYMENT FOR CERTAIN DENTAL EXPENSES CHARGED BY A DENTIST OR PHYSICIAN TO A COVERED PERSON. COVERED BENEFITS ARE OUTLINED BELOW.

REFER TO DENTEMAX ID CARD

MAXIMUM BENEFIT

Maximum Calendar Year Benefit per Covered Person for Class I, II, and III Services Combined $1,500

Maximum Lifetime Benefit per Covered Person for Orthodontia
(for Dependents up to age nineteen [19] years).....$1,500

DEDUCTIBLE AMOUNTS

Class I: Preventive Services ..... None

Class II and III: Basic Services and Major Services:
Each Covered Person, each Calendar Year $25

Maximum per Family per Calendar Year.....$50

Class IV: Eligible Orthodontic Treatment ..... $100 lifetime per dependent child

COINSURANCE

Non-Network Provider expenses are subject to Usual, Customary and Reasonable (UCR) Fees

	NETWORK	NON-NETWORK
Class I: Eligible Preventive Services……..	100%	100%
Class II: Eligible Basic Services……	80%	80%
Class III: Eligible Major Services……	80%	80%
Class IV: Eligible Orthodontic Treatment) ……. (Dependents up to age nineteen [19] years)	50%	50%

DESCRIPTION OF DENTAL BENEFITS

Dental Benefits will be paid as shown in the Schedule of Dental Benefits providing the person has dental coverage and the charges incurred are Eligible Expenses and not shown as limited or excluded under the Plan.

DENTAL DEDUCTIBLES AND COINSURANCE

DEDUCTIBLE: The Calendar Year Deductible, as shown in the Schedule of Dental Benefits, is the amount of Eligible Basic (Class II) and/or Major Expenses (Class III) which must be incurred by each Covered Person (if applicable) before any benefits are payable, unless stated otherwise in the Schedule of Dental Benefits.

If more than one (1) Covered Person in a Family incurs expenses during a Calendar Year and the accumulated expenses payable by those Individuals exceed the Family Deductible shown in the Schedule of Dental Benefits, the Deductible will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

The Calendar Year Deductible does not apply to eligible Diagnostic and Preventive Care Services (Class I) or Orthodontic Treatment (Class IV).

The Plan Administrator reserves the right to allocate the Deductible amount to any Eligible Expenses and to apportion the benefits to the Covered Person and any assignee. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

COINSURANCE: Unless otherwise shown, the Plan will pay the applicable percentage rate as shown in the Schedule of Dental Benefits for Eligible Expenses which exceed the Calendar Year Deductible, if applicable, up to the maximums shown in the Schedule of Dental Benefits.

CALENDAR YEAR MAXIMUM: The maximum payable for all Eligible Expenses for each Covered Person shall not exceed in the aggregate the Calendar Year Maximum amount shown in the Schedule of Dental Benefits.

SELECTING A DENTIST: You may choose to go to any licensed Dentist. However,

> If Your Plan includes a Network, Your Out-of-Pocket expenses (Your Cost Share) are likely to be less. Network Providers agree to accept payment according to the Network fee schedule. You will not be balance billed for any Covered amounts in excess of the negotiated fee schedule.
>
> If You go to a Dentist who does not participate in the Network, the Coinsurance percentage paid is often less than the Network percentage, meaning Your out-of-pocket expenses (Your Cost Share) may be more than if You used a Network Provider. In addition, You may be responsible for paying any amount in excess of the Usual, Customary and Reasonable (UCR) fee.

To see which providers are Network Providers, refer to the website and telephone number on the back of Your identification card.

USUAL, CUSTOMARY AND REASONABLE (UCR): *"UCR"* means allowable fees for Covered Services. For Network Providers, UCR means the professional fees the Plan has negotiated with them. For Non-Network Providers, UCR means a fee level that the Plan has determined to be appropriate for a particular dental service, which often is less than the Providers actually charge. The Plan will not pay that portion of Non-Network Provider fees that exceeds UCR. You may be responsible for paying that amount.

PREDETERMINATION OF BENEFITS: Whenever recommended dental treatment is expected to exceed $200, the Covered Person is encouraged to submit a Treatment Plan to the Third Party Administrator for review prior to treatment. The Treatment Plan should consist of:

1. A list of the services to be performed, using the American Dental Association nomenclature and codes;

2. A written description of the proposed treatment from the treating Dentist;

3. Supporting pre-treatment X-rays showing the Covered Person's dental needs;

4. Itemized cost of the proposed treatment; and

5. Any other appropriate diagnostic materials requested by the Third Party Administrator.

A Predetermination of benefits is not a guarantee of benefits payable. You will be advised if any services are limited or not covered. If You elect a costlier treatment than is determined by the Plan Administrator to be satisfactory for treatment of the condition, payment will be limited to the lesser of the UCR charge. (subject to any applicable Deductible, Coinsurance and/or Calendar Year Maximum).

INCURRED DATE OF DENTAL SERVICES: An Eligible Expense is considered incurred on the date the service, supply, or treatment is furnished except that incurred dates for these special procedures are to be as follows:

1. Charges for dentures or partials are incurred on the date the dentures are placed;

2. The date band or appliance is inserted for Orthodontic Treatments;

ELIGIBLE DENTAL EXPENSES AND LIMITATIONS

SUBJECT TO THE EXCLUSIONS, LIMITATIONS, DEFINITIONS, REQUIREMENTS, AND PROVISION OF THIS PLAN, AND USUAL, CUSTOMARY AND REASONABLE FEES, THE ELIGIBLE EXPENSES COVERED UNDER THIS PLAN ARE LIMITED TO THE FOLLOWING:

1. For any dental or medical services performed by a Physician and/or services which benefits are otherwise provided under a medical-surgical plan of the Covered Person

CLASS I: ELIGIBLE PREVENTIVE EXPENSES. Eligible Preventive Care Expenses are limited to expenses for the following services:

1. Routine examinations, limited to a total of two (2) per Calendar Year.

2. Routine prophylaxis (cleaning), Scaling and polishing, limited to a total of two (2) per Calendar Year.

3. Topical application of fluoride, limited to one (1) per Calendar Year, for Covered Persons under age nineteen (19) years.

4. Bitewing X-rays, limited to a total of two (2) per Calendar Year.

CLASS II: ELIGIBLE BASIC EXPENSES. Eligible Basic Expenses are limited to expenses for the following services:

1. X-Rays:

    a. Full mouth or Panoramic X-rays once in any three (3) Calendar Years;
    b. Intraoral periapical or occlusal X-rays-single films;

2. Biopsies and examinations of oral tissue on the gum line or tooth area only.

3. Emergency care/exam and palliative treatment for relief of dental pain. Expense incurred is payable as a separate benefit only if no other service, other than X-rays, was rendered during the same visit.

4. Space Maintainers to replace prematurely lost teeth for Dependent children under age fifteen (15) years and adjustments to the space maintainers within six (6) months of insertion.

5. Problem focused or specialty exams.

6. Diagnostic consultation with a Dentist other than the one (1) providing treatment. Benefits are payable only if no other treatment, other than X-rays, is performed during the visit.

7. Therapeutic injections/drugs.

8. Restorative Dentistry:

    a. Fillings of amalgam (permanent and baby teeth);
    b. Filling of silicate, acrylic, plastic, resin, or gold foil;
    c. Acid etch is included with the restoration;
    d. Pin retention, if done in conjunction with an amalgam or composite restoration;

9. Endodontic services (treatment of disease within a tooth, including root canal):

    a. Pulpotomy;
    b. Root canal therapy;
    c. Vital pulpotomy;
    d. Apicoectomy (removal of part of the tooth root) and retrograde filling;
    e. Root resection;
    f. Hemisection;
    g. Apical curettage;

h. Apexification.

10. Periodontic services (treatment of diseases of the gums and tissues of the mouth):

    One (1) of the following procedures per area of the mouth in any Calendar Year:
    - Gingivectomy, per quadrant;
    - Gingival curettage, per quadrant;
    - Gingival flap procedure, per quadrant;
    - Mucogingival surgery, per quadrant;
    - Osseous (bone) surgery, per quadrant;
    - Periodontal Scaling and Root Planning, per quadrant;
    - Osseous grafts, single site;
    - All Periodontic grafts;
    - Periodontal occlusal adjustment, if done with Periodontal surgery;
    - Full mouth Debridement;

11. Periodontal prophylaxis, including the Periodontal exam, limited to a total of two (2) Periodontal prophylaxis treatments in any Calendar Year.

12. Oral Surgery:

    a. Simple extraction;
    b. Surgical extraction, including impactions. (If a payment has been made through the Medical Benefits Plan, please provide a Medical Explanation of Benefits).
    c. Root removal (surgical removal of residual root);
    d. Incision and drainage of an abscess;
    e. General anesthesia (subject to approval of the plan administrator to be covered under this Plan);
    f. Surgical preparation of ridge for dentures (alveoplasty & alveoectomy);
    g. Frenectomy of the front lip, if Dentally Necessary;

CLASS III: ELIGIBLE MAJOR EXPENSES. Eligible Major Expenses are limited to expenses for the following services:

1. Restorative services (crowns, inlays and onlays):

    a. Precious metal inlays and onlays, if tooth can't be restored by amalgam or composite fillings;
    b. Crowns and abutments, if tooth can't be restored by a filling (limited to plastic or stainless steel crowns for children under sixteen [16] years), using the following materials:

        - Plastic: acrylic, pre-fabricated, or processed to metal;
        - Precious (full or ¾-cast), semi-precious, or non-precious (full cast) metal;
        - Porcelain or porcelain fused to metal, for the second bicuspid or Anterior Teeth only;
        - Stainless steel;
        - Gold thimble;

    c. Post and cores, if tooth has had root canal therapy;
    d. Re-cementing of crowns, inlays, bridge-work, or space maintainers;
    e. Crown build-up, if done for Endodontically treated teeth which require crowns, the build-up is included with the crown allowance;
    f. Repair of crowns to replace a broken facing with other facing;
    g. Repairs (other than relining) and adjustments to dentures, limited to repairs or adjustments done more than twelve (12) months after initial insertion;
    h. Other repairs include repairing broken complete or partial dentures and replacing broken teeth or clasps.

2. Initial installation of fixed bridges or full or partial removable dentures (a bridge or denture is considered to be installed for the first time if it doesn't replace any existing bridge or denture) if proof is given that:

    a. The service is Medically/Dentally Necessary due to the extraction of a decayed or diseased tooth, and is received within twelve (12) months after the tooth is extracted;
    b. You are covered under the Plan at the time of the extraction; and

c. The service includes replacing the extracted tooth.

3. Bridges and dentures:

   a. Full dentures, complete or immediate, upper or lower;
   b. Partial dentures, including two (2) clasps and rests:
      - Acrylic base, upper or lower;
      - Precious metal palatal/lingual bar, acrylic base, upper or lower;
      - Removable;
      - Add tooth, with or without clasp.
   c. Additional clasps and rests;
   d. Dentures relined:
      - At least one (1) year after initial insertion;
      - No more than once in any two (2) Calendar Years;
   e. Fixed bridges:
      - Cast gold, cast semi-precious, and cast non-precious pontic;
      - Slotted facing steeles and slotted pontic Tru-pontic;
      - Pin facing;
      - Porcelain fused to metal pontic (replacing the second bicuspid or an Anterior Tooth);
      - Plastic processed to metal pontic;
      - Maryland bridge;
   f. Stress breakers

4. Replacements of, or additions to, partial dentures or fixed bridgework if proof is given that:

   a. The service is Medically/Dentally Necessary due to the extraction of a decayed or diseased natural tooth that occurs while covered under this Plan and the service is completed within twelve (12) months after the tooth was extracted; or

   b. Your existing denture or bridgework can't be repaired and the replacement is made after the later of:
      - Five (5) years after the existing appliance was installed; and
      - Five (5) years after You became covered under the Plan.

5. Replacements of full dentures if proof is given that Your existing denture or bridgework can't be repaired, and the replacement is made after the later of:

   a. Five (5) years after the existing appliance was installed; and
   b. Five (5) years after You became covered under the Plan.

Temporary restorations and appliances and one (1) year follow-up care for all major restorative services will be considered part of the final service, rather than as a separate service, and reduced from final services.

CLASS IV: ELIGIBLE ORTHODONTIA TREATMENT EXPENSES. Benefits for Orthodontic Treatment are paid up to the maximum shown in the Schedule of Dental Benefits. Eligible Orthodontia Treatment Expenses are limited to expenses for the following services:

- Diagnostic, evaluation, and pre-care procedures;
- Fixed or removable appliances; and
- Full-banded treatment.

Although diagnostic procedures are included as part of Orthodontic coverage, the course of Orthodontic Treatment begins when the first Orthodontic band or appliance is inserted and ends when the last band or appliance is taken off. Two or more courses of treatment are treated as one (1) course unless they are separated by at least two (2) years.

Payment Method: If You are charged a flat fee for the course of Orthodontic Treatment, or pay the full cost up front with no contract, full reimbursement of benefits will be paid.

DENTAL EXCLUSIONS AND LIMITATIONS

THE FOLLOWING ARE NOT ELIGIBLE EXPENSES UNDER THE DENTAL PLAN:

1. Not specifically listed as a Covered Service on the Schedule of Dental Benefits and those listed as not covered on the Schedule of Dental Benefits.

2. Any Cosmetic Service, including but not limited to, bleaching procedures or preventive restoration such as veneers, laminate veneers or crowns;

3. Preventive control programs including, but are not limited to: sealants, oral hygiene instructions, plaque control or dietary planning;

4. Fees for services rendered by someone other than a licensed Dentist or auxiliary personnel under the Dentist's direct supervision, except that Scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist. The treatment must be rendered under the direct supervision and guidance of the Dentist in accordance with generally accepted dental standards;

5. Any services or supplies provided for Inpatient or Outpatient Hospital care or for services or supplies provided in relation to care by a surgical treatment facility. (Refer to Your Medical Plan).

6. Services of an anesthesiologist, unless shown as a Covered Service and Medically/Dentally Necessary;

7. Any service which is deemed Experimental, Investigational or Unproven in nature, based on standards of the American Dental Association;

8. Treatment which does not meet accepted standards of dental practice, based on standards of the American Dental Association;

9. Replacement of a crown, onlay, inlay, bridge or denture within six (6) months following the date of original installation;

10. Replacement of a bridge or denture that can be made useable according to dental standards;

11. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance within five (5) years of the insertion or placement of the original prosthetic device or dental appliance;

12. Treatment an Individual receives before coverage starts or after it ends, unless otherwise stated herein;

13. Services to replace a tooth that was missing prior to the Effective Date of coverage, including congenitally missing teeth;

14. Services or supplies for which there is no legal obligation to pay, or charges which would not be made but for the availability of benefits under this Plan;

15. Any charge for any condition, disability or expense resulting from or sustained as a result of war or act of war, declared or undeclared;

16. Dental services or supplies received through a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar person or group;

17. Any dental or medical services performed in which the benefits are otherwise covered under the medical plan.

18. Any expense which exceeds the UCR expense for the care rendered;

19. Any expenses for preparing dental reports or itemized bills;

20. Any expense for professional services performed by a person who ordinarily resides in the Covered Person's household or who is related to the Covered Person, such as a spouse, parent, child, brother, or sister, whether such relationship is by blood or exists in law;

21. Any expenses which would entitle the Covered Person to any benefit under Worker's Compensation Act or similar legislation or which is due to Injury or Illness arising out of or in the course of any occupation or employment for wage or profit;

22. Any expense for care or treatment provided or furnished by the United States Government or in any other Hospital operated by a government of any country if in-service related;

23. Dental Implants, including placement and restoration of Implants and all services, supplies, crowns and surgery related to Implants.

24. Expenses for procedures or appliances, whose main purpose is to change the vertical dimension, or stabilize periodontal involved teeth (i.e. occlusal guards, athletic guards, splinting occlusal adjustments), unless otherwise shown as covered;

25. Accident related services are not covered under the Dental Benefits, however it may be covered under the Employer’s medical benefit plan;

26. Expenses for whitening teeth;

27. Expenses for removal of enamel projections;

28. Expenses for temporary services, including but are not limited to temporary crowns, temporary bridges, temporary dentures;

29. All services in connection with treatment of Temporomandibular Joint Syndrome (TMJ): a collection of associated symptoms before final diagnosis of Joint Dysfunction or Derangement is made, including treatment, and orthodontic or dentofacial orthopedic appliances and adjustments thereto;

30. Claims not submitted to the Third Party Administrator on a timely basis as required by this Plan Document.

SCHEDULE OF VISION BENEFITS

Benefit Maximum

Vision Examination	$33.00
Lenses (per pair)	
Single Vision	$42.00
Bifocal	$69.00
Trifocal	$100.00
Lenticular	$125.00
Contact Lenses	$110.00
Frames	$50.00

Benefit Period

Vision Examination	Once (1) every Calendar Year
Frames and Lenses*	Once (1) every two (2) years, adults eighteen (18) years old and older Once (1) every year, Dependents under eighteen (18) years old

* Covered contact lenses are in lieu of all other frames and lenses for the Benefit Period.

ELIGIBLE VISION EXPENSES AND LIMITATIONS

Covered Vision Services

Benefits are payable up to the amounts listed in the Schedule of Benefits, per Benefit Period specified, for Covered Vision Services incurred for the following professional fees and materials:

1. Professional vision examination: This examination is a complete analysis of the vision functions, including the prescription of lenses where indicated. Benefits are payable for Covered Services incurred to the maximum amount shown in the Schedule of Benefits.

2. Lenses: Benefits are payable for lenses including single vision, bifocal, trifocal or more complex lenses, and necessary for the patient's visual welfare. Covered materials include tints, plastic multi-focal lenses and oversized lenses.

3. Frames: Benefits are payable as shown in the Schedule of Benefits.

4. Contact lenses: Benefits are payable for necessary contact lenses as shown in the Schedule of Benefits. Covered contact lenses are in lieu of all other frames and lenses for the Benefit Period.

VISION EXCLUSIONS AND LIMITATIONS

1. Orthoptics or vision training, subnormal vision aids, aniseikonic lenses or plano (non-prescription) lenses.

2. Replacement of lenses and frames furnished under this program which are lost, stolen or broken, except at the normal intervals when benefits are otherwise available.

3. Medical or surgical treatment of the eyes.

4. Any eye examination required by an employer as a condition of employment; or any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.

5. Any service or supply not listed in the Vision Schedule.

6. Sunglasses, frames for sunglasses or safety lenses or goggles.

7. Frames or lenses not needed to correct abnormal vision.

8. Expenses incurred after the termination date of coverage under this Plan.

9. Expenses for Lasik eye surgery are not covered by the vision plan.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

COVERAGE PROVIDED UNDER THE PLAN FOR COVERED EMPLOYEES SHALL BE IN ACCORDANCE WITH THE EMPLOYEE'S ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS INCLUDED HEREIN AND COVERAGE CLASSIFICATION (IF ANY) UNDER THE PLAN.

ALL COVERAGE UNDER THE PLAN SHALL BEGIN AT 12:01 A.M. STANDARD TIME, ON THE DATE SUCH COVERAGE IS EFFECTIVE.

BENEFITS AVAILABLE:

Employee Coverage: All benefits are offered as a package. If the Employee elects coverage under the Plan, all benefits must be elected. Likewise, if an Employee waives coverage, all benefits will be waived.

Dependent Coverage: All benefits for Dependents are offered as a package. If the Employee elects Dependent coverage under the Plan, all benefits must be elected. This means that the Employee may elect Dependent coverage under Dental and Vision benefits; or Dependent coverage may be waived for Dental and Vision benefits. However, a Dependent will only be covered for a particular benefit if the Employee is also covered for that benefit.

LIMITED SCOPE BENEFITS AVAILABLE: "This Plan is considered a limited-scope dental and vision plan under 29 C.F.R. §2590.732(c)(3). Although dental and vision may be offered to You at the same time as Your other benefits, it may be offered under a separate policy and may not be an integral part of the group health plan. If it is offered as a separate benefit, You have the right to decline election for the dental and vision benefit. If You elect to receive coverage for the benefit, You may be required to pay additional premiums or contributions for that coverage. It is the Plan Administrator's good faith interpretation of the current law that the limited-scope benefits provided under this Plan are not subject to the restriction of annual and Lifetime limits under the PPACA. Therefore, the benefits offered under this Plan will be subject to benefit limits as expressly stated in the Plan. In the event that our interpretation is inconsistent with any rules promulgated by the U.S. Department of Health and Human Services or other governmental authorities in the future, the Plan will notify You accordingly.

EMPLOYEE ELIGIBILITY: An Employee eligible for coverage under the Plan shall include only an Employee who is in an eligible Class and meets the following conditions:

1. Is employed by the Employer on a regular basis and who is scheduled to work a minimum of thirty (30) hours per week. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he receives regular earnings from the Employer; or

2. Elected Officials; and/or

3. Part-Time City Council Members; and/or

4. Part-Time Referees; and/or

5. Attorneys of the City Law Department; and/or

6. Full-Time members of the Canton Recreation Department;

7. Any Employee meeting the requirements set forth in the A.F.S.C.M.E. or a Non-A.F.S.C.M.E. negotiated collective bargaining agreement; and/or

8. Has met the required Waiting Period.

WAITING PERIOD: The Waiting Period is the length of time immediately before Your coverage can become effective during which You must be an eligible Employee as provided for as follows:

With respect to such an eligible person who becomes employed by the Employer on or after the Effective Date of this Plan, the Effective Date is: the first of the month coincident with or next following sixty (60)-days.

With respect to such an eligible person employed by the Employer prior to the Effective Date of this Plan who has not completed the prior plan's Waiting Period, the Effective Date is: the first of the month coincident with or next following sixty (60)-days with credit given for days satisfied prior to this Plan's Effective Date.

With respect to such eligible person employed by the Employer prior to the Effective Date of this Plan, who has completed the Waiting Period under the previous Plan, the Effective Date is: the Plan's Effective Date.

RESCISSION OF COVERAGE: A rescission of coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide a person with coverage, just as if that person never had coverage under the Plan. Coverage can only be rescinded if a Covered Person (or a person seeking coverage on behalf of that Covered Person), performs an act, practice, or omission that constitutes fraud; or unless a Covered Person (or a person seeking coverage on behalf of that Covered Person) makes an intentional misrepresentation of material fact, as prohibited by the terms of this Plan. Coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by the Covered Person's Employer.

Such person will be provided with thirty (30) calendar days advance notice before the coverage is rescinded. Such a person has the right to request an internal appeal of a rescission of coverage. Once the internal appeal process is exhausted, such person has the additional right to request an independent External Review. To get more information or to request an internal or External Review, please contact the Plan.

EMPLOYEE ENROLLMENT

INITIAL ENROLLMENT: An eligible Employee's coverage under this Plan shall become effective on the date the Employee has completed the Waiting Period provided he agrees to make any required contribution and makes written application to the Plan Administrator for coverage on or before that date.

OPEN ENROLLMENT: An Open Enrollment Period ("Open Enrollment") will be held each year by the Employer during the month of December and January, during which eligible Employees and their Dependents will be able to change some of their benefit decisions based upon which benefits are then available. Benefit decisions made during Open Enrollment will be effective February 1st and will remain in effect for a year unless there is a change in Family status or special circumstances allow for a Special Enrollment (as explained below).

SPECIAL ENROLLMENT: If an eligible Employee does not apply for coverage on or before the date he completes the Waiting Period because he had other health coverage as of that date, the Employee's coverage under this Plan will become effective as of:

1. In the case of COBRA continuation coverage, the date such coverage has exhausted (exhaustion of a COBRA continuation period means that an Individual's COBRA continuation period ceases for any reason other than either failure of the Individual to pay premiums on a timely basis or for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan); or

2. In the case of coverage that is not COBRA continuation coverage:

    a. The date the Employee's other coverage terminates as a result of loss of eligibility for coverage as a result of separation, divorce, cessation of Dependent status, death, termination of employment, reduction in the number of hours worked, or any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    b. In the case of other coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because the Employee no longer resides, lives, or works in the service area (whether or not within the choice of the Employee), and no other benefit package is available to the Employee; or
    c. A situation in which another plan no longer offers any benefits to the class of similarly situated Individuals that includes the Employee; or
    d. The date the Employee's other coverage terminates as a result of Employer contributions being terminated.

In order for coverage to become effective as of the date the Employee's other coverage has terminated, the Employee must make written application for coverage under this Plan within thirty-one (31) days of that date.

If an eligible Employee waived coverage under this Plan and makes written application to cover a new spouse, newborn child, or an adopted child, or an eligible older age child, the Employee (and his eligible spouse, if applicable) must also make written application for coverage within thirty-one (31) days of marriage, the child's date of birth or, in the case of

adoption, thirty-one (31) days of the date of the actual adoption or the date of placement for the purpose of adoption. Coverage will become effective for the Employee and such eligible Dependents as of the date of marriage, child's date of birth, or the date of adoption or placement for the purpose of adoption.

Special Rules relating to Medicaid and Children's Health Insurance Program
If coverage is terminated for an Employee (or Dependent) under a Medicaid Plan or under a state Children's Health Insurance Program (CHIP) as a result of loss of eligibility for such coverage, the Employee must make written application to enroll under this Plan no later than sixty (60) days after the date of such termination, for such coverage to become effective as of the date the other coverage has terminated.

Likewise, if an Employee (or Dependent) becomes eligible for assistance in the purchase of employment based coverage under Medicaid or a state Children's Health Insurance Program (CHIP), the Employee must make written application to enroll under this group health plan, no later than sixty (60) days after the date the Employee (or Dependent) is determined to be eligible for such assistance.

LATE ENROLLMENT: Late Enrollment is not allowed under this Plan. If an eligible Employee and/or Dependent fails to enroll during the Initial Enrollment Period or a Special Enrollment Period, that eligible Employee and/or Dependent will not be eligible for coverage until the following Open Enrollment Period.

TERMINATION OF EMPLOYEE COVERAGE: Coverage under this Plan shall terminate immediately upon the earliest of the following dates or as otherwise determined by Your Employer:

1. The end of the month in which employment terminates; or
2. The date the Employee involuntarily terminates; or
3. With self-pay; Up to one (1) year from the date the Employee begins an approved personal leave of absence if he is not entitled or is no longer entitled to a leave of absence under the Family and Medical Leave Act. Such leave will run concurrently with any other approved leave of absence to which the Employee is entitled under the Plan; or
4. With self-pay; Up to one (1) year from the date the Employee begins an approved medical leave of absence if he is not entitled or is no longer entitled to a leave of absence under the Family and Medical Leave Act. Such leave will run concurrently with any other approved leave of absence to which the Employee is entitled under the Plan; or
5. Twelve (12) weeks from the date the Employee begins an approved personal or medical leave of absence under the Family and Medical Leave Act ("FMLA"). Such leave is subject to all provisions of the "FMLA" and will run concurrently with any other approved leave of absence to which the Employee is entitled under the Plan; or
6. The end of the month following the date the Employee ceases to be in a class of Employees eligible for coverage (such as becoming a part-time Employee, being laid off, or taking an unapproved personal or medical leave of absence) unless the Employee's coverage is continued due to a temporary lay-off, approved personal leave of absence, or approved medical leave of absence; or
7. The end of the period for which an Employee makes his last contribution for coverage, if a contribution is required; or
8. The date the Plan terminates; or
9. The date the Employee dies; or
10. The date the Employee becomes a Full-Time member of the Armed Forces of any country. However, if a Covered Employee temporarily leaves the Employer because of military service, the applicable provisions of the Uniformed Services Employment and Re-Employment Rights Act of 1993 will apply.

REINSTATEMENT OF COVERAGE: If an eligible Employee's coverage terminates by reason of discharge, voluntary termination, expiration of an extension of coverage due to lay-off or a granted approved leave of absence, the Waiting Period will be waived for that eligible Employee (and any of his or her eligible Dependents who were covered under the Plan) if he or she is rehired within a thirteen (13) week period immediately following the date of his or her coverage terminating under the Plan.

If the Employee is rehired and returns to work within a thirteen (13) week period from the initial start date of the break in coverage due to discharge, voluntary termination, expiration of an extension of coverage due to lay-off or a granted approved leave of absence, the Employee's coverage under the Plan (and that for his eligible Dependents, if previously covered) will become effective on the date he or she returns to work as an eligible Employee (and if he or she agrees to pay any required contribution and applies for coverage for himself or herself and his or her Dependents, if applicable, within thirty (30) days of that date).

If the Employee is rehired and returns to work more than a thirteen (13) week period after the date of discharge, voluntary termination, expiration of an extension of coverage due to lay-off or a granted approved leave of absence, the Employee may be considered a new employee, and the Initial Enrollment section will apply.

All other "Eligibility, Effective Date and Termination" provisions as shown in this section will apply.

DEPENDENT ELIGIBILITY: Eligible Dependents are:

1. The Employee's legal spouse (if legally married in any state) except; If a spouse has medical coverage offered through their Employer, they are required to take that coverage on themselves in order to be covered under City of Canton's coverage as the secondary plan. If the spouse's medical coverage contribution is in excess of $200 Single per Month, he or she may waive that coverage and enroll for coverage under the City's Plan and the Employee's premium contribution will be increased to a negotiated amount per pay.

2. Under federal law, the Employee's married or unmarried child who:

    a. is a natural child, legally adopted child, child placed for legal adoption, foster child; stepchild, or child for whom the Employee has obtained legal custody or guardianship; and
    b. has not yet reached his or her twenty-sixth (26th) birthday.

Please note that federal law does not require the child to live with or be financially dependent upon the parent.

Coverage for adopted children begins on the earlier of: the date of the actual adoption; or the date of placement for the purpose of adoption and is continuing unless the placement is disrupted prior to legal adoption of the child.

Coverage for children who have been placed under the Employee's legal custody or guardianship will begin on the date the Employee files for legal custody or guardianship unless legal custody or guardianship is not granted to the Employee.

Coverage continues up to the Limiting Age. The "*Limiting Age*" is upon reaching twenty-six (26) years of age.

COVERAGE REQUIRED BY A "QUALIFIED MEDICAL CHILD SUPPORT ORDER": Any requirement that would disqualify a Dependent child from being eligible under the Plan will be waived if the Plan has been issued a "qualified medical child support order" by a court of law for a Dependent child of a Covered Employee or of a Covered spouse. To be considered "qualified", the following information must be included in the order:

1. The name and last known mailing address of the Covered Person and each child to be covered.

2. A reasonable description of the type of coverage to be provided by the Plan to each child or the manner in which the type of coverage is to be determined.

3. The period to which the order applies.

4. Each Plan to which the order applies.

In order for the child's coverage to become effective as of the date the court order has been issued, the Employee must apply for coverage within the time periods specified under the section entitled "Dependent Enrollment".

COVERAGE REQUIRED BY A "NATIONAL MEDICAL SUPPORT NOTICE": Any financial dependency requirement or residency requirement that would disqualify a Dependent child from being eligible under the Plan will be waived if the Employer has been issued and receives an "appropriately completed" "National Medical Support Notice" by a court or by a State child support agency for a Dependent child of a non-custodial eligible Employee, provided the notice is qualified.

An "appropriately completed" notice must contain:

1. The name of an Issuing Agency;

2. The name and last known mailing address of an Employee who is a Covered Person or who is eligible for participation under the Plan, who is a non-custodial parent obligated by a State court or administrative order to provide medical child support for one or more children named in the Notice;

3. The name and mailing address of one or more alternate recipient(s) (an "alternate recipient" means any child of a Covered Person or an eligible Employee who is recognized under a medical child support order as having a right to enrollment under the Plan) or the mailing address of a substituted official or agency; and

4. The Family group health care coverage required by the child support order is identified and available.

If the Employer receives a "National Medical Support Notice" for a Dependent child of a non-custodial Employee, who is an eligible Employee as defined by the Plan, and such notice is determined to be "appropriately completed" by the Plan Administrator, then the notice will be considered to be a "Qualified Medical Child Support Order" which will be recognized by the Plan and such Dependent child will become eligible under this Plan.

If a "National Medical Support Notice" is determined to be a qualified notice, then, in accordance with the ERISA and the Child Support Performance and Incentive Act:

1. If the eligible Employee, who is the non-custodial parent, is not enrolled for coverage under the Plan, then such Employee must enroll for Employee and Dependent coverage (for the applicable Dependent child) under the Plan. Coverage for the eligible Employee and his applicable Dependent child or children will become effective on the date the order is issued, if the Plan Administrator deems the notice is qualified; such Employee must complete an enrollment form.

2. If the Employee is covered under the Plan prior to the date of the order, then the Dependent child's coverage will become effective as of the date the order has been issued; the Employee must apply for coverage for such Dependent child.

3. If Employee contributions are required for coverage under this Plan, then the Employer must withhold the necessary contributions for coverage from the Employee's paycheck, if it is determined that Federal or State (of the Employee's principal place of employment) withholding limitations or prioritization rules permit the withholding. An Employee may contest the wage withholding; the Employee should contact the agency that issued that order.

4. If the Plan has an "Open Enrollment" provision, then such provision will not apply to the Employee nor will it apply to the applicable Dependent child.

5. Coverage of a Dependent child because of qualified "National Medical Support Notice" will terminate on the earlier of: a) the date the court or administrative child support order is no longer in effect; b) the date the Employer cannot withhold a sufficient amount of the required Employee contributions (if any) because of income withholding limitations; c) the date the child has comparable coverage in effect through another group or individual plan (other than a government-sponsored plan, such as Medicare or Medicaid); or d) the date coverage would end for similarly situated Dependent children.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under the Plan and all other eligibility, Effective Date and termination provisions will apply.

COVERAGE FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN: The Limiting Age requirement is waived for any mentally or physically handicapped child who is covered under this Plan, provided that the child is incapable of self-sustaining employment beginning prior to the date on which the Dependent child reaches the Limiting Age. Proof of incapacity and dependence must be furnished to the Plan Administrator by the Employee within ninety (90) days of the date on which the Limiting Age is attained. Additional proof may be required from time to time.

In the event the child is no longer mentally or physically handicapped, then such extension of coverage will terminate within thirty (30) days of the date the child is declared no longer mentally or physically handicapped by a Physician.

THOSE PERSONS SPECIFICALLY <u>EXCLUDED</u> FROM THE DEFINITION OF A DEPENDENT ARE ANY PERSON ELIGIBLE FOR COVERAGE UNDER THIS PLAN AS AN INDIVIDUAL EMPLOYEE EXCEPT THAT:

1. When both spouses are covered as Employees, they can enroll each as single Employees or one Employee and spouse. They may not each enroll as Employee and spouse.

2. When both spouses are covered as Employees under this Plan, only one may cover Dependent children, not both.

3. When the Employee is also an eligible Dependent under this Plan, the Employee may be covered as an individual Employee or an eligible Dependent, but not as both.

If an Employee is eligible to be covered under this Plan and is also an eligible Dependent child under another Employee and has elected to be covered as a Dependent, that Employee will, upon reaching the Limiting Age for a Dependent, be automatically covered as an Employee.

The Dependent benefits provided under the Plan for a Covered Employee shall be in accordance with the Dependent Eligibility, Effective Date and Termination Provisions included herein and his coverage classification (if any) under the Plan.

DEPENDENT ENROLLMENT

INITIAL ENROLLMENT: If an Employee agrees to pay any required contribution, his eligible Dependent(s) will become covered on the latest of the following dates:

1. The Employee's Effective Date provided the Employee makes written request for Dependent coverage during the time periods specified under the section "Employee Enrollment" entitled Initial Enrollment; or

2. The date the Dependent meets the definition of an Eligible Dependent if the Employee makes written application for Dependent coverage on or before the thirty-first (31st) day after the date his Dependent becomes eligible.

SPECIAL ENROLLMENT: If an eligible Employee does not apply for coverage within thirty-one (31) days of a Dependent becoming eligible for coverage because the Dependent had other health coverage as of the date coverage under this Plan would have otherwise become effective, the Dependent's coverage under this Plan will become effective as of:

1. In the case of COBRA continuation coverage of the Dependent, the date such coverage has exhausted (exhaustion of a COBRA continuation period means that an Individual's COBRA continuation period ceases for any reason other than either failure of the Individual to pay premiums on a timely basis or for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan); or

2. In the case of coverage that is not COBRA continuation coverage;

    a. The date the Dependent's other coverage terminates as a result of loss of eligibility for coverage as a result of separation, divorce, cessation of Dependent status, death, termination of employment or reduction in the number of hours worked. or any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    b. In the case of other coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because the Dependent no longer resides, lives, or works in the service area (whether or not within the choice of the Dependent), and no other benefit package is available to the Dependent;
    c. A situation in which another plan no longer offers any benefits to the class of similarly situated individuals that includes the Dependent; or
    d. The date the Dependent's other coverage terminates as a result of contributions being terminated.

In order for coverage to become effective as of the date the Dependent's other coverage has terminated, the Employee must make written application for coverage under this Plan within thirty-one (31) days of that date.

If an eligible Employee waived coverage under this Plan and makes written application to cover a new spouse, newborn child or an adopted child, or an eligible older child, the Employee (and his eligible spouse, if applicable) must also make written application for coverage within thirty-one (31) days of marriage, the child's date of birth or, in the case of adoption, thirty-one (31) days of the date of the actual adoption or the date of placement for the purpose of adoption. Coverage will

become effective for the Employee and such eligible Dependents as of the date of marriage, child's date of birth, or the date of adoption or placement for the purpose of adoption.

Special Rules relating to Medicaid and Children's Health Insurance Program
If coverage is terminated for an Employee (or Dependent) under a Medicaid Plan or under a state Children's Health Insurance Program (CHIP) as a result of loss of eligibility for such coverage, the Employee must make written application for Dependent coverage under this group health Plan, no later than sixty (60) days after the date of such termination, for coverage to become effective as of the date the other coverage has terminated.
Likewise, if an Employee (or Dependent) becomes eligible for assistance in the purchase of employment based coverage under Medicaid or a state Children's Health Insurance Program (CHIP), the Employee must make written application for Dependent coverage under this group health Plan, no later than sixty (60) days after the date the Employee (or Dependent) is determined to be eligible for such assistance.

LATE ENROLLMENT: Late Enrollment is not allowed under this Plan. If an eligible Employee and/or Dependent fails to enroll during the Initial Enrollment period or a Special Enrollment period, that eligible Employee and/or Dependent will not be eligible for coverage until the following Open Enrollment period.

TERMINATION OF DEPENDENT COVERAGE: A Dependent's Coverage shall automatically terminate immediately upon the earlier of the following dates:

1. The date of divorce from the Employee for a Dependent spouse; or The date of legal separation from the Employee for a Dependent spouse; or the earlier of: The date on which a divorce is granted from the Employee for a Dependent spouse; or The date on which a legal separation is granted from the Employee for a Dependent spouse; or

2. The end of the month a Dependent child ceases to meet the definition of an eligible Dependent under the Plan; or

3. The date coinciding with termination of the Employee's coverage under the Plan; or

4. If an Employee fails to make a required contribution for Dependent coverage, the end of the period for which the Employee made his last required contribution; or

5. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefits; or

6. The date the Employee dies.

In order for any Dependent whose coverage is terminated to be eligible for COBRA continuation coverage, the Employee must notify the Plan Administrator within (sixty) 60 days of the date the Dependent is no longer eligible for coverage under the Plan.

CHANGES IN BENEFITS OR ELIGIBILITY PROVISIONS (APPLIES TO COVERED PERSONS): If there is a change in the benefits or eligibility provisions under the Plan, expenses incurred on or after the Effective Date of the change will be payable in accordance with the amended Plan provisions.

FAMILY AND MEDICAL LEAVE ACT

ELIGIBLE EMPLOYEES: Provided the Employer is a "covered" Employer under the Family and Medical Leave Act ("FMLA"), You will be eligible for an extension of benefits under the FMLA if You are covered under this Plan and have worked for the Employer for at least twelve (12) months and 1,250 hours in the twelve (12) months immediately preceding the start of Your leave of absence and You are employed at a work site that has at least fifty (50) employees within seventy-five (75) miles of that work site, unless state law requires otherwise. The twelve (12) months of service need not be consecutive. Each partial week on the payroll is counted as one (1) week, and fifty-two (52) weeks are considered as twelve (12) months.

During a qualified leave of absence, You will be subject to the same healthcare benefits and Plan provisions as active Employees.

You may be entitled to other job-protection rights under the FMLA and You should consult Your Employer's FMLA policy for information regarding the same; this section addresses healthcare benefits continuation.

QUALIFYING EVENTS: The following situations will qualify You for an extension:

1. Birth or adoption of a child by the Employee or the Employee's spouse;

2. Placement in the Employee's or Employee's spouse's care of a foster child;

3. The Serious Health Condition of an Employee's spouse, child or parent;

4. Your own Serious Health Condition;

5. Any qualifying exigency arising out of the fact that the Employee's spouse, son, daughter or parent is a military member on covered active duty; or

6. Twenty-six (26) weeks to care for a Covered service member with a serious Injury or Illness if the Employee is the spouse, son, daughter, parent or next-of-kin of the service member.

SERIOUS HEALTH CONDITION: "*Serious Health Condition*", as it applies to the FMLA, means an Illness, Injury, impairment, or physical or mental health condition involving a period of incapacity and/or either Inpatient care or "continuing treatment by a health care Provider", or requiring absences on a recurring basis or for more than three days for treatment or recovery.

NOTICE TO THE EMPLOYER: You must give thirty (30) days advance notice to the Employer of Your need for a leave of absence. Whenever possible, You must try to set up Your planned leave schedule so as not to disrupt the Employer's operations. In cases when advance notice is not possible (i.e., the leave is not foreseeable, e.g., a premature birth or accident), You must give notice to the Employer as soon as You can; ordinarily this should be within two (2) business days of the date of the event.

You must give the Employer the following information at that time:

1. The reason for the leave; and

2. The date You will begin Your leave of absence; and

3. How long You expect to be on leave.

If an Emergency exists where it is not possible for You to notify the Employer, Your spouse or other Family member may provide such notice.

If You do not give the Employer adequate notice of a leave of absence, the Employer may deny Your leave of absence.

EXHAUSTION OF OTHER PAID BENEFITS: Any accrued/available PTO/vacation from Your Employer must be used, and will run concurrently with, any FMLA leave. To be paid while on FMLA leave, Your Employer may require that You use available PTO/vacation or be eligible for Short Term Disability (STD) benefits and that the remainder of the FMLA leave will be unpaid. FMLA will run concurrently with workers' compensation and/or short term disability.

MEDICAL CERTIFICATION: If You are seeking leave due to a Serious Health Condition, the Employer may require You to obtain certification from a qualified healthcare Provider that You are unable to work or perform Your duties due to a Serious Health Condition. If the Employer requests such certification You must provide it, at Your own expense, within fifteen (15) calendar days of Employer's request. The Employer may also require, at its expense, a second opinion and, if the first two opinions disagree, a third medical opinion.

If Your leave is foreseeable and You do not provide the Employer with such certification within the time limit shown above, the Employer may deny Your leave of absence.

The Employer may also require re-certification of Medical/Dental Necessity every thirty (30) days, but not less than thirty (30) days from the last certification, or if there is a change in Your medical condition or if he receives information questioning the validity of the most recent certification.

If the leave is for Your own Illness, the qualified healthcare Provider must certify that You are unable to perform work or to perform the essential functions of Your own job due to Your Serious Health Condition.

If the leave is for the Serious Health Condition of Your spouse or other eligible Family member, You must certify the care You will be providing to that Family member and the Family member's attending Physician must certify the need for such care.

INTENT TO RETURN TO WORK: While You are on leave, the Employer may require You to provide periodic reports to him regarding Your status and Your intent to return to work.

CONTRIBUTIONS: If You are required to make a contribution for coverage as an active Employee and this is an unpaid leave of absence, You and the Employer must work out, in advance, an acceptable method of payment for Your contributions during Your leave. Once the method of payment has been established, the Employer will provide You, in advance, a written notice of the terms and conditions of such payments. During Your leave, Your contribution may not be more than what You would have paid as an active Employee.

If You do not make any agreed upon payment within 30 days after the date it is due, the Employer may terminate Your coverage at the end of the thirty (30)-day "grace period".

If You fail to return to work after Your FMLA leave of absence other than due to continuation of the condition (i.e., You are not seriously ill and You did not return to work and continue to work for at least thirty [30] calendar days), the Employer may recover the full cost of coverage from You. The "full cost of coverage" is the amount of COBRA continuation coverage less the two percent (2%) administration fee.

MAXIMUM LENGTH OF FMLA BENEFITS EXTENSION: If You work in the twelve (12) months immediately preceding the start of Your leave of absence and are eligible for an approved leave of absence under the FMLA You may take up to twelve (12) weeks of FMLA leave (or twenty-six [26] weeks for military caregivers) in a twelve (12)-month period. This twelve (12)-month period will be determined by the Employer (i.e., it may be a Calendar Year or a rolling period of twelve [12] months). The Employer must notify You sixty (60) days in advance of any change made to the term of the twelve (12)-month leave period.

If the reason for the approved leave of absence is the birth or adoption of a child by You or Your spouse or placement in Your or Your spouse's care of a foster child, Your entitlement to the twelve (12)-week FMLA leave of absence ends twelve (12) months after the date of birth or placement.

If maternity is the reason for the approved leave of absence, periods taken for medical disability and periods taken as a personal leave of absence both count towards the twelve (12)-week maximum FMLA Benefits extension. (For example, if You take six [6] weeks of leave due to medical disability, only six [6] more weeks remain under FMLA for the personal leave of absence.)

If You and Your spouse work for the same Employer, the *combined* maximum amount of FMLA leave You may both take under the following conditions is twelve (12) work weeks during any twelve (12)-month period:

1. The birth or adoption of a child; or

2. Placement in Your care of a foster child; or

3. The serious health condition of a parent.

CHANGES IN COVERAGE AND/OR BENEFITS: While You are on an approved leave of absence, You may make coverage changes, such as adding coverage for a newborn child, on the same basis as if You were an Active Employee and any changes made to the Plan's benefits or eligibility provisions while You are on an approved leave of absence will apply to You and Your Dependents on the same basis as any other Covered Person.

RETURNING TO WORK: You will continue to be covered under the Plan on the same basis as any other Covered Person as long as You return to work for the Employer before the maximum length of time for the approved FMLA leave of absence, or any approved leave extension with benefits, or other legally required extension of benefits, has expired.

EMPLOYEE'S RIGHTS: The Employer may not in any way interfere with Your rights under the FMLA or discriminate or retaliate against You for opposing any practice made unlawful by the FMLA, or interfere with, restrain, or deny any person the exercise of any right provided by the FMLA.

APPLICABLE STATE FAMILY OR MEDICAL LEAVE LAWS: If You are employed in a state with its own family or medical leave related law, that state’s law’s provisions will also apply to You. To the extent there is any conflict between provisions of this Plan section and any applicable state law provision, the Employee will be governed by the law that provides greater Family or medical leave rights.

CONTINUATION OF COVERAGE (“COBRA”)

BENEFITS MAY BE EXTENDED UPON REQUEST FOR COVERED EMPLOYEES AND/OR THEIR COVERED DEPENDENTS IF QUALIFIED PER ONE OF THE FOLLOWING "QUALIFYING EVENTS":

EMPLOYEE: For a Covered Employee to be qualified, the Covered Employee must become ineligible for group coverage because of termination of employment (other than because of gross misconduct), reduction in the number of hours worked, or the Employer filing for reorganization under Chapter XI of the Bankruptcy Law.

DEPENDENT: For a Covered Dependent to be qualified, they must become ineligible for group coverage because of one of the following:

1. Death of the Employee;

2. Termination of the Employee's employment (other than because of gross misconduct) or reduction in the number of hours of employment;

3. Divorce or legal separation;

4. The Covered Employee becoming entitled to Medicare benefits;

5. A child ceasing to meet the definition of Dependent;

6. The Employer files for reorganization under Chapter XI of the Bankruptcy Law.

The Covered Person must notify the Plan Administrator within sixty (60) days in the event that his spouse or children are no longer eligible Dependents. For all other qualifying events, the Employer must notify the Plan Administrator within thirty (30) days of the event. The Plan Administrator must then notify the Qualified Beneficiary of his or her right to continue during the next fourteen (14) days.

The term "*Qualified Beneficiary*" is a Covered Employee and/or the spouse or child of a Covered Employee, who on the date immediately before a qualifying event occurred, was covered for benefits under this Plan. Also, a Qualified Beneficiary is a child who is born to or placed for adoption with the Covered Employee during the period of continuation of coverage under COBRA.

The Continuation coverage will be identical to the coverage provided under the Plan to similarly situated persons who have not experienced a qualifying event. The Qualified Beneficiary does not have to provide evidence of good health to continue coverage.

Each Qualified Beneficiary can elect coverage independently. Benefits under the Plan will be offered on the same basis as they are to Active Employees and their Covered Dependents. For example, if medical coverage, dental coverage and vision coverage are offered to Active Employees as a "package", the Qualified Beneficiary can elect coverage as a package or elect medical coverage only. If medical coverage, dental coverage and vision coverage are offered to Active Employees as separate options, the Qualified Beneficiary can elect such coverage as separate options.

TIME FRAME FOR ELECTION OF CONTINUATION OF COVERAGE: The Covered Person must elect coverage within 60 days of the latest of the following dates: the date coverage terminates, or the date shown on the Plan Administrator's notice of the right to elect Continuation.

If Continuation of coverage is elected, the Qualified Beneficiary is required to pay a premium for his or her Continuation coverage. This premium generally equals the Employer's cost of providing coverage for similarly situated beneficiaries, plus a two percent (2%) fee for administrative costs.

IF CONTINUATION OF COVERAGE IS ELECTED, PREMIUMS ARE DUE FROM THE QUALIFIED PERSON AS FOLLOWS:

1. The first premium payment(s) may be deferred. However, such deferred payment period cannot exceed the forty-five (45)-day period immediately following the date You send the election form to the Plan Administrator.

2. Payment for any subsequent month of continued coverage must be paid as of the premium due date.

3. If payment is not made by the premium due date there is a thirty (30)-day grace period for such payment. If the premium is not paid during that thirty (30)-day period, continued coverage will terminate as of the end of the last date for which a premium payment was made.

CONTINUATION OF COVERAGE FOR QUALIFIED EMPLOYEES WILL END THE EARLIER OF:

1. The date on which coverage ceases under the Plan due to failure to make the required premium, in full, on time; or

2. The date the qualified Employee becomes covered, after electing Continuation coverage under this Plan or under any other health plan; or

3. The end of eighteen (18) months from the date the Continuation began if Continuation was due to the Employee becoming ineligible for group benefits, due to termination of employment, or reduction of hours; or

4. The date that the qualified Employee becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing Continuation coverage under this Plan; or

5. The date on which the Plan is terminated in its entirety.

CONTINUATION OF COVERAGE FOR QUALIFIED DEPENDENTS WILL END THE EARLIER OF:

1. The date on which coverage ceases under the Plan due to failure to make the required premium, in full, on time; or

2. The date the qualified Dependent becomes covered, after electing Continuation coverage under this Plan or under any other group health plan; or

3. The end of eighteen (18) months from the date the Continuation began if Continuation was due to the Employee becoming ineligible for group benefits due to termination of employment or reduction of hours; or

4. The end of thirty-six (36) months from the date the Employee becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing Continuation coverage under this Plan, but not less than the end of eighteen (18) months from the date the Continuation began; or

5. The end of thirty-six (36) months from the date the Continuation began if Continuation was for other qualifying reasons; or

6. The date that the qualified Dependent becomes entitled to benefits (under Part A, Part B, or both) after electing Continuation coverage under this Plan; or

7. The date on which the Plan is terminated in its entirety.

EXCEPTIONS: There are three (3) exceptions:

1. If an Employee or family member is disabled at any time during the first sixty (60) days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is twenty-nine (29) months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the twenty-nine (29)-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to City of Canton or the Plan Administrator both within the eighteen (18)-month coverage period and within sixty (60) days after the date of the determination.

2. If a second qualifying event that gives rise to a thirty-six (36)-month maximum coverage period (for example, the Employee dies or becomes divorced) occurs within an eighteen (18)-month or twenty-nine (29)-month coverage period, the maximum coverage period becomes thirty-six (36) months from the date of the initial termination or reduction in hours for the Spouse or Dependent child.

3. If within the eighteen (18) month period after Medicare entitlement, the Employee experiences a qualifying event (due to termination or reduction of hours worked) then the period of continuation for family members, other than the Employee, who are qualified beneficiaries, is up to thirty-six (36) months from the date of Medicare entitlement.

If the Employee experiences a qualifying event on or before the date of Medicare entitlement, or after the expiration of the eighteen (18) month period after Medicare entitlement, both Employee and family members who are qualified beneficiaries are entitled to up to eighteen (18) months from the date of the qualifying event.

If the Employee's Medicare entitlement follows an initial qualifying event (due to termination or reduction of hours worked) and would have resulted in a loss of coverage had it occurred before the initial qualifying event, then other family members who are qualified beneficiaries will be allowed to elect COBRA coverage up to thirty-six (36) months from the date of the initial qualifying event.

EXTENSION OF THE LENGTH OF COBRA CONTINUATION COVERAGE: If You elect Continuation coverage, an extension of the maximum period of coverage may be available if a Qualified Beneficiary is disabled or if a second qualifying event occurs. You must notify the Plan Administrator, in writing, within sixty (60) days of a disability or a second qualifying event in order to apply to extend the period of Continuation coverage. Failure to provide written notice within the sixty (60)-day period may affect the right to extend the period of Continuation coverage.

SPECIAL PROVISIONS FOR A TOTALLY DISABLED BENEFICIARY: A disabled Qualified Beneficiary may elect to extend existing Continuation coverage for himself and for his covered spouse and/or Covered Dependents, from eighteen (18) months up to twenty-nine (29) months provided all of the following conditions are met:

1. The Qualified Beneficiary's Continuation coverage is due to the Covered Employee's loss of coverage under this Plan because of termination of employment (other than gross misconduct) or due to a reduction in the number of hours worked;

2. The Qualified Beneficiary is determined by the Social Security Administration (SSA) to be disabled; and, the disability must have started at some time before the 60th day of Continuation coverage and the disability must be ongoing at least until the end of the 18-month period of Continuation coverage;

3. The Qualified Beneficiary must give the Plan Administrator a copy of the Social Security disability determination notice within sixty (60) days of the latest of the following dates: a) date of the SSA's disability determination; b) date of the qualifying event; c) date on which the Qualified Beneficiary would lose coverage under the Plan; or d) date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice through the Plan's summary plan description or through the initial COBRA Continuation notice provided by the Employer;

4. The Qualified Beneficiary must provide a copy of the Social Security disability determination notice to the Plan Administrator before the end of the first eighteen (18) months of his or her Continuation period; and

5. He must notify the Plan Administrator that he elects the extension before the end of the first eighteen (18) months of his or her Continuation period; he must also specify if his or her Covered Dependents elect to extend their coverage. (If the disabled Qualified Beneficiary is a Dependent, also refer to the paragraph entitled "Second Qualifying Event".)

The cost of Continuation coverage for months one (1) through eighteen (18) will be at the rate of up to 102% of the Employer's cost for such coverage; the cost of Continuation coverage for months nineteen (19) through twenty-nine (29) will be at the rate of up to 150% of the Employer's cost for providing such coverage to similarly situated beneficiaries.

If Social Security determines during the extended eleven (11)-month period that the beneficiary is no longer disabled, the beneficiary must notify the Plan Administrator within thirty (30) days of Social Security's final determination. Continuation will then be terminated in the month that begins more than thirty (30) days after the final determination is made by Social Security.

If an extension of the maximum COBRA coverage period is going to be denied, the Plan Administrator must provide You with a written notice of unavailability within fourteen (14) days after receiving any notice from a Qualified Beneficiary that is a notice of a determination of disability. A termination notice will be provided to You as soon as practicable following the Plan Administrator's determination that Continuation coverage shall terminate.

SECOND QUALIFYING EVENT: An eighteen (18)-month extension of coverage will be available to Dependents who elect Continuation coverage if a second qualifying event occurs during the first eighteen (18) months of Continuation coverage. The maximum amount of Continuation coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying events may include the death of a Covered Employee, divorce or separation from the Covered Employee, the Covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a second qualifying event, but only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan Administrator in writing within sixty (60) days after a second qualifying event occurs if You want to extend Your Continuation coverage. Failure to notify the Plan Administrator in writing within the sixty (60)-day period may affect the right to extend the period of Continuation coverage.

If an extension of the maximum COBRA coverage period for a second qualifying event is going to be denied, the Plan Administrator must provide You with a written notice of unavailability within fourteen (14) days after receiving any notice from a Qualified Beneficiary that is a notice of a second qualifying event. A termination notice will be provided to You as soon as practicable following the Plan Administrator's determination that Continuation coverage shall terminate.

Termination Notice: After receiving written notice of a qualifying event, the Plan Administrator must notify You under the following circumstances: 1) if an Individual does not qualify for COBRA continuation coverage. A notice explaining why the Individual is not entitled to such coverage must be provided to the Individual within fourteen (14) days of receiving the written notice from the Employee or the Qualified Beneficiary; 2) if COBRA coverage is terminated earlier than the time period for which COBRA Continuation coverage is normally available for the applicable qualifying event. This notice will be provided as soon as administratively practicable after the termination decision is made; it will explain why and when the Continuation coverage was terminated.

ACQUIRED DEPENDENTS: Any Qualified Beneficiary may elect coverage for a Dependent acquired during a period of Continuation. The acquired Dependent must be a person who would have been an eligible Dependent had he been acquired by an active Employee enrolled under the normal terms of the Plan. Qualified Beneficiaries must apply for coverage for the acquired Dependent(s) under the same provision as those in effect for similarly situated Covered Employees. An acquired Dependent is a "Qualified Beneficiary".

WAIVING COBRA COVERAGE DURING THE ELECTION PERIOD: If a Qualified Beneficiary signs a waiver of his rights to Continuation coverage during his election period, he cannot revoke his waiver unless he does so within sixty (60) days from the later of: 1) the date coverage terminates; or 2) the date shown on the Plan Administrator's notice of the right to elect Continuation.

If the Qualified Beneficiary revokes the waiver within such time periods shown above: 1) the maximum period of Continuation will be the same as it would have been had the Individual not waived Continuation coverage; and 2) claims incurred from the date the Individual lost coverage to the date the Individual revoked the waiver will not be covered under the Plan.

INCAPACITATION: If a Qualified Beneficiary is or becomes physically or mentally incapacitated and cannot waive coverage or make an election to continue coverage for himself within the sixty (60)-day election period, then the election period will be tolled (suspended) until a legally-appointed guardian or representative is designated to act on behalf of the Qualified Beneficiary, providing the guardian or representative is designated within thirty (30) days after the date the Qualified Beneficiary becomes incapacitated or dies. For example, if the Qualified Beneficiary becomes incapacitated (or dies) with ten (10) days remaining in a COBRA election period and the Qualified Beneficiary has not made an election, then the legally-appointed guardian or representative will have ten (10) days from the date of his appointment to elect the Continuation coverage on behalf of the beneficiary, providing the appointment is within the specified time period.

If the Qualified Beneficiary elects Continuation coverage and later becomes incapacitated (or dies) and misses a premium deadline under the Continuation coverage due to the incapacitation, then the deadline for that premium payment will be tolled (suspended) until thirty (30) days from the date a legally-appointed guardian or representative is designated to act on behalf of the Qualified Beneficiary, providing the guardian or representative is designated within thirty (30) days after the date the beneficiary becomes incapacitated or dies.

CLAIMS INFORMATION

INSTRUCTIONS FOR FILING CLAIMS UNDER THE PLAN: All claims submitted for payment must include the Employee's name and Member I.D., patient's name and relationship to the Employee, date of service, diagnosis, type of service, the amount charged for each service, the Employer's group number, and name of Employer. Application for Benefits (Claim Form) is available in the Customer Service Center. You may also choose to visit the Third Party Administrator's website at www.aultcare.com. Services include Provider Directory, Frequently Asked Questions (FAQs) and online forms.

NOTICE OF CLAIM: All claims must be received by the Third Party Administrator within twenty-four (24) months of the Incurred date to be eligible for coverage.

HOSPITAL/PROVIDER/AFFILIATE EXPENSES: Most expenses are billed directly by the Hospital, Provider, or Affiliate to the Third Party Administrator (TPA).

IF THIS PLAN IS THE SECONDARY PAYOR, the Explanation of Benefits (sometimes called an "EOB") from the primary payor must be provided to this Plan before the claim payment process can be completed. An EOB describes how the primary payor handled Your Claim. An EOB is not a bill. The Provider may send You a bill, if needed. Please note that if this Plan is the secondary payor, the Physician may require You to pay Your dental expenses and to submit Your own claim forms for reimbursement to You. The Customer Service Center is available to assist You in this matter.

AN EXPLANATION OF BENEFITS (EOB) form can be obtained by utilizing the website at www.aultcare.com or paper copies can be mailed to the Employee upon request, showing how the benefits were calculated. Explanation of Benefits questions about benefit coverage, claim processing or claim status should be referred to the Customer Service Center at **330-363-6360** or **1-800-344-8858.**

SEND ALL CLAIMS TO:

THE ADDRESS SHOWN ON THE BACK OF YOUR I.D. CARD

VERIFICATION OF BENEFITS: If You want to verify eligibility and benefits before charges are incurred, please call the **Customer Service Center** at this number: 330-363-6360 or 1-800-344-8858.

VOLUNTARY PREDETERMINATIONS OF BENEFITS: If the Plan does not require approval (Prior Authorization) of a service or treatment before the service or treatment is rendered, but You voluntarily elect to request a written benefit determination for the proposed service or treatment, then this will be considered an informal inquiry. A Claim for Benefits does not constitute a Pre-Service Claim unless the Plan requires Prior Authorization for the proposed service or treatment.

TIME LIMIT FOR FILING POST-SERVICE CLAIMS: Affirmative proof of loss for which a Post-Service Claim is made must be furnished to the Third Party Administrator within one (1) year of the date the claim was incurred. However, upon termination of the Plan, final claims must be received within sixty (60) days of termination.

TIME LIMITS FOR PROCESSING POST-SERVICE DENTAL CLAIMS: Except as otherwise provided herein, upon receipt of a Post-Service dental claim (a claim for services which have already been rendered), the Third Party Administrator will furnish a written notice to the Employee with the initial benefits determination (whether the claim is eligible or denied, in whole or in part) within thirty (30) days of receipt of the claim at the Third Party Administrator's place of business. If, for reasons beyond the control of the Third Party Administrator, a determination cannot be made at the end of the thirty (30)-day period, then an additional period of fifteen (15) days will be permitted to make the benefits determination. The benefits determination will be provided on the Explanation of Benefits Form (EOB). If there is insufficient information to make a claim determination within the time periods described, the claim will be denied (an Adverse Benefit Determination) for lack of information; You will be provided a written notification in the EOB or in another written or electronic format. If the claim was denied because there was insufficient information to make a determination, then a description of any additional material or information necessary to make the benefit determination will be provided.

CONCURRENT CARE DETERMINATIONS: If the Plan has approved an ongoing course of treatment to be provided over a period of time, any reduction or termination of such a Prior Authorized course of treatment shall be considered an Adverse Benefit Determination. The Third Party Administrator shall notify the claimant of such an Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated. Any request to extend a course of treatment beyond the period or number of treatments previously approved shall, in the case of an Urgent Care claim, be decided by the Third Party

Administrator within twenty-four (24) hours after receipt of the claim, provided that such a claim must be made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period or number of treatments previously approved.

CLAIM DETERMINATIONS BY THE THIRD PARTY ADMINISTRATOR: If a Claim for Benefits is rejected due to lack of information, is denied or if the claim is not paid in full (an Adverse Benefit Determination), the Third Party Administrator will specify the reason for any denial or benefit reduction on the Explanation of Benefits Form (EOB) or in another written or electronic format, with reference to the Plan provisions on which the determination was made.

REQUEST FOR DOCUMENTS RELATED TO A CLAIM DENIAL: If an initial Claim for Benefits is either denied, or if the claim is not paid in full (a Post-Service Claim), the Covered Person (or an authorized representative, including a health care Provider, acting on behalf of the Covered Person) is entitled to make a written request to the Third Party Administrator for access to and copies of all documents, records and other information relevant to the claim; this information will be provided free of charge to the Covered Person (or to the authorized representative). "Relevant" means any document, record, or other information which: 1) was relied upon in making the determination; or 2) was submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon; or 3) demonstrates compliance with the administrative procedures and safeguards required; or 4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the diagnosis, whether or not such advice or statements were relied upon in making the determination.

The Plan's claims procedures include administrative safeguards and processes designed to ensure and to verify that benefit claims determinations are made in accordance with the Plan Document and, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants.

REQUEST FOR AN INTERNAL APPEAL: If the Covered Person, or an authorized representative (including a health care Provider acting on behalf of the Covered Person), elects to appeal a claim involving an Adverse Benefit Determination, such appeal must be submitted in writing within 180 days after the date of the Adverse Benefit Determination notice and will be determined through an internal appeal process as follows. The Covered Person (or an authorized representative of the Covered Person) may submit written comments, documents, records, and other information relating to the claim when making the appeal. Claim appeals submitted after 180 days will be denied, unless the Covered Person was legally incapable of making a written appeal within the 180-day limit, but in no case will the claim appeal be considered if it is submitted one year after the date the notice is received.

If a claimant failed to provide sufficient information for the Third Party Administrator to determine whether, or to what extent, benefits are covered or payable under the Plan, the Third Party Administrator shall notify the claimant of the claimant's obligation to submit additional information within forty-eight (48) hours.

Before the Plan Administrator decides an internal appeal based on a new or additional rationale, the Plan Administrator will provide the Covered Person or its authorized representative, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the internal appeal. Such evidence will be provided to the Covered Person or its authorized representative as soon as reasonably possible and sufficiently in advance of the date on which the internal appeal will be decided to give the Covered Person or its authorized representative a reasonable opportunity to respond prior to that date.

Notwithstanding, if new or additional evidence is received so late that it would be impossible to provide it to the Covered Person or its authorized representative in time for the Covered Person or its authorized representative to have a reasonable opportunity to respond, the period for providing a notice of final internal Adverse Benefit Determination is tolled (suspended) until such time as the Covered Person or its authorized representative has a reasonable opportunity to respond. After the Covered Person or its authorized representative responds, or has a reasonable opportunity to respond but fails to do so, the Third Party Administrator shall notify the Covered Person or its authorized representative of the Plan's benefit determination as soon as a Plan Administrator acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

The Third Party Administrator will review the claim appeal and provide a written notice of benefit determination on the review within thirty (30) days. The written notice will be provided to the Covered Person or its authorized representative in accordance with federal law and in a culturally and linguistically appropriate manner. The notice shall include information sufficient to identify the claim involved (including the date of service, the health care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning). The notice will also include a description of any further rights to appeal including the opportunity to request an External Review.

A full and fair review of a claim appeal involving Adverse Benefit Determination is required; the claim appeal must be reviewed by someone other than the Individual that denied, in whole or in part, the original claim; the review cannot be conducted by a subordinate of the Individual that made the original determination. The review may not rely on the initial Adverse Benefit Determination; it must take into account all comments, documents, records and other information submitted with the claim appeal letter, without regard to whether such information was previously submitted or relied upon in the initial determination.

Prior to adjudicating any internal appeal which requires a medical judgment be made (for example, Medical/Dental Necessity or Experimental treatment determinations), an appropriate healthcare professional must be consulted; such professional must be someone other than the healthcare professional consulted during the initial processing of the claim. If the Covered Person (or the authorized representative, including a health care Provider acting on behalf of the Covered Person) makes a written request for the name of the health care professional(s) consulted by the Third Party Administrator in connection with an appeal of an Adverse Benefit Determination involving Medical/Dental Necessity, such information must be provided to the Covered Person free of charge.

IF AN INTERNAL CLAIM APPEAL IS DENIED: There are two (2) options available if an appeal of an Adverse Benefit Determination is denied:

1. If the initial claim appeal of an Adverse Benefit Determination is denied (in whole or in part) by the Third Party Administrator, the Covered Person (or the authorized representative of the Covered Person) may voluntarily elect an additional level of appeal, including an External Review by an Independent Review Organization, arbitration or any other form of alternative dispute resolution, provided:

    a. The Third Party Administrator will not assert a failure to exhaust administrative remedies where a Covered Person elects to pursue a claim in court rather than through the voluntary level of appeal;
    b. The Third Party Administrator agrees that any statute of limitations applicable to pursuing the Covered Person's claim in court will be extended (tolled) during the period of the voluntary appeal process;
    c. The voluntary level of appeal is available only after the Covered Person has pursued the initial appeal of an Adverse Benefit Determination;
    d. The Third Party Administrator provides the Covered Person with sufficient information (at no cost to the Covered Person) to make an informed judgment about whether to submit a claim through the voluntary appeal process. The Covered Person's decision will have no effect on the Individual's rights to any other benefits under the Plan. The rules of the appeal will be provided to the Covered Person. The Covered Person will have a right to representation. The process for the selection of the decision maker for the appeal will be explained and the circumstances, if any, that may affect the impartiality of the decision maker; and
    e. No fees or costs are imposed on the Covered Person as part of the voluntary appeal process.

2. If the internal claim appeal of an Adverse Benefit Determination is denied (in whole or in part) by the Third Party Administrator, then the Covered Person has the right to bring a civil action under section 502(a)(1)(B) of ERISA.

You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office.

INTENT FOR CLAIMS PROCEDURES AND CLAIMS APPEALS: It is the Plan Administrator's intent to comply with the Claims Regulations provisions of ERISA. However, if the Plan fails to establish or follow reasonable claims procedures, as defined by ERISA, then a Covered Person shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under section 502(a) of ERISA.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE FOR THE APPEAL OF A POST-SERVICE CLAIM: A Covered Person may elect to have another individual file an appeal of a Post-Service Claim on behalf of the Covered Person involving an Adverse Benefit Determination. To designate the individual or Provider as an "authorized representative", the Covered Person must send a written statement to the Third Party Administrator, naming the individual or Provider designated to act on behalf of the Covered Person for the review of the Adverse Benefit Determination (an assignment of benefits by a Covered Person does not constitute a designation of an authorized representative). All communications regarding the appeal will be directed to the authorized representative, unless the Covered Person includes a written request to receive copies also.

EXAMINATION: The Plan Administrator shall have the right and opportunity to have the Covered Person examined whose Injury or Illness is the basis of a Post-Service Claim hereunder when and as often as it may reasonably require during the

time the claim is pending under the Plan. However, if a claim is pended for the results of the examination, the claim determination must be made under the time limits described above for processing a Post-Service Claim. If the examination is not conducted within the time limits described, then the claim will be denied, but can be appealed in accordance with the appeals procedure for Post-Service Claims. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in a case of death where it is not forbidden by law.

PAYMENT OF CLAIMS: All Plan benefits are payable to the Employee, or subject to any written direction of the Employee. All or a portion of any indemnities provided by the Plan on account of Hospital, nursing, medical or surgical services may, at the Employee's option and unless the Employee requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the Hospital or person rendering such service; however, if any such benefit remains unpaid at the death of the Employee or if the Employee is a minor or is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt and discharge of any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Employee; wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the Plan Administrator's obligation to the extent of such payment and the Plan Administrator will not be required to see the application of the money so paid.

REQUEST FOR EXTERNAL REVIEW: Before You ask for an External Review, You first must let the Plan reconsider any Adverse Benefit Determination through the Internal Review process except in the limited circumstances described in the section on Expedited Reviews below. You may be able to skip the Internal Review process and go directly to an External Review by an Independent Review Organization. The Plan must have Your permission before an External Review is conducted instead of first going through an Internal Review. If You go directly to an External Review, instead of first going through an Internal Review, You will lose the right of reconsideration and Internal Review. The Plan will not grant any reconsideration or Internal Review after a decision has been made by the Independent Review Organization. If You have questions on how this works or how to ask for an External Review, contact the Customer Service Center.

If You request an External Review for any reason, You will be required to authorize the release of Your medical records to conduct the External Review.

You may submit in writing any additional information You believe should be considered as part of the External Review. This additional information must be submitted by You within ten (10) days of the date You receive notice from The Third Party Administrator that Your request for an External Review is complete. In the case of an Expedited Review, You must submit the information immediately.

If You would like more information about the External Review process, including forms needed to commence an External Review and authorization forms, please contact the Customer Service Center.

EXTERNAL REVIEW BECAUSE SERVICES ARE NOT COVERED OR COVERAGE IS RESCINDED: If the Third Party Administrator makes an Adverse Benefit Determination because the service is not covered by this Plan, the service is excluded, You are not eligible for coverage or Your coverage was rescinded, You may request an External Review to be conducted. You must request this review within 180 calendar days of receiving notice of the Adverse Benefit Determination as part of the Internal Review. Your request must be in writing to the Third Party Administrator, except if You request an Expedited Review, which is explained below.

EXTERNAL REVIEW WHEN DENIAL IS BECAUSE SERVICES ARE NOT MEDICALLY/DENTALLY NECESSARY, APPROPRIATE OR EFFECTIVE: If the Plan makes an Adverse Benefit Determination based on medical judgment or medical information because the service does not meet requirements for Medical/Dental Necessity, appropriateness, health care setting or level of care, You may request an External Review from an Independent Review Organization. The Independent Review Organization is not connected with this Plan.

You must request this review within 180 calendar days of receiving notice of the Adverse Benefit Determination as part of the Internal Review. Your request must be in writing except if You request an Expedited Review, which is explained below.

The Independent Review Organization will review Your medical records to determine if the service under review meets requirements for Medical/Dental Necessity, appropriateness, health care setting or level of care. If the Independent Review Organization finds that the service does meet Plan requirements for Medical/Dental Necessity, appropriateness, health care setting or level of care, the Plan will cover that service according to the terms of the Plan. If the Independent Review Organization finds that the service does not meet Plan requirements for Medical/Dental Necessity, appropriateness, health care setting or level of care, the Plan will not pay for it.

EXTERNAL REVIEW WHEN DENIAL IS BECAUSE SERVICES ARE EXPERIMENTAL OR INVESTIGATIVE: You may ask for an External Review when the Plan makes an Adverse Benefit Determination because services were determined to

be Experimental or Investigative, except if the services are explicitly excluded under the Plan. To qualify for this External Review, You must meet all of the following criteria:

1. You request an External Review no later than 180 calendar days after the receipt of notice of the decision in the Internal Review to deny coverage.

2. Your Physician certifies that one of the following situations applies to Your condition:

   a. Standard therapies have not been effective in improving Your condition.
   b. Standard therapies are not medically appropriate for You.
   c. There is no available standard therapy covered by the Plan that will benefit You more than the therapy You or Your Physician requested.

3. You have gone through all the steps in the Internal Review process.

4. The drug, device, procedure, or other therapy would be covered if it were not considered to be Experimental or Investigative.

If Your treating Provider certifies that the requested services would be significantly less effective if not promptly initiated, You may request an Expedited Review of a denial of Experimental or Investigative services. Procedures for initiating an Expedited Review are explained below.

REQUEST FOR EXPEDITED REVIEW: You may ask for an Expedited External Review by phone, fax, e-mail, orally or in writing in any of the following circumstances:

1. Your treating Physician certifies that a denial of coverage involves a medical condition that could seriously jeopardize Your life or health if treated after the time frame of an Expedited Review and You have filed a request for an Expedited Internal Review;

2. Your treating Physician certifies that a denial of coverage involves a medical condition that could seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function if treated after the time frame of a standard External Review;

3. A denial of coverage concerns an admission, availability of care, continued stay, or health care service for which You received Emergency Services, but You have not yet been discharged from a facility.

If a request for an Expedited Review is complete and eligible, the Third Party Administrator will transmit all necessary documents and information to the assigned Independent Review Organization, which will give You a decision within seventy-two (72) hours of being assigned the Expedited Review.

RIGHT TO REQUEST AN EXPEDITED REVIEW BEFORE AN INTERNAL REVIEW IS COMPLETED: In certain circumstances, You may request an Expedited Review without having to first complete an Internal Review. An External Review may be requested before an Internal Review is completed in the following circumstances:

1. Your treating Physician certifies in writing that You have a medical condition where the time frame for completing an Expedited Review after an Internal Review would seriously jeopardize Your life, health or Your ability to regain maximum function, in which case You may request an Expedited Review simultaneously with an Internal Review;

2. An Adverse Benefit Determination is based on a determination that the recommended or requested service is Experimental or Investigational and Your treating Physician certifies in writing that the service would be significantly less effective if not promptly initiated, in which case You may request an Expedited Review simultaneously with an Internal Review; or

3. You have requested an Internal Review and the Plan has not issued a decision to You within thirty (30) days following the date You filed a Request for an Internal Review, and You have not requested or agreed to any delay.

DETERMINATION BY THE INDEPENDENT REVIEW ORGANIZATION: If the Independent Review Organization decides that the service is Medically/Dentally Necessary, appropriate and effective, the Plan will cover the service. You must pay

the applicable Cost Share. If the Independent Review Organization decides that the service is not Medically/Dentally Necessary, appropriate or effective, the Plan will not cover it.

For further information on how this works or to request an Internal or External Review, please contact or submit Your request to the Third Party Administrator.

Please be advised that based on the specific circumstances of Your service, the above referenced reviews may be conducted in conjunction with your medical-surgical plan.

COORDINATION OF BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan.

The order of benefit determination rules govern the order in which each Plan will pay a Claim for Benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Eligible Expense.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance plans and contracts, health insuring corporation ("HIC") contracts, closed panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental Plan, as permitted by law.

   2. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental Plans, unless permitted by law.

   Each contract for coverage under 1. or 2. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

   When this Plan is primary, it determines payment for its benefits first before those of any other Plan. When this Plan is secondary, it determines its benefits after those of the Primary Plan and may reduce the benefits it pays so that all Plan benefits will not exceed the Secondary Plan's normal liability when combined with primary carrier's payment.

D. Allowable Expense is a health care expense, including Cost Share, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the UCR of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:

   1. The difference between the cost of a Semi-Private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.

   2. If a person is covered by two (2) or more Plans that compute his or her benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar

reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by two (2) or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include Prior Authorization of admissions, or Preferred Provider arrangements.

E. Closed panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of Providers that has contracted with or is employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a closed panel Provider.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one half of the Calendar Year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage, without regard to the benefits of any other Plan.

1. Except as provided in Paragraph 2 below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel Plan to provide Non-Network Benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent, for example as an Employee, Covered Person, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent, and primary to the Plan covering the person as other than a Dependent (e.g. a retired Employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an Employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
iii. However, if one parent's Plan has some other coordination rule (for example, a "gender rule" which says the father's Plan is always primary), this Plan will follow the rules of that Plan.

b. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
ii. If a court decree states that both parents are responsible for the Dependent child's Health Care expenses or health care coverage, the provisions of Subparagraph a. above shall determine the order of benefits;
iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph a. above shall determine the order of benefits; or

c. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

i. The Plan covering the custodial parent;
ii. The Plan covering the spouse of the custodial parent;
iii. The Plan covering the non-custodial parent; and then
iv. The Plan covering the spouse of the non-custodial parent.

d. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph a. or b. above shall determine the order of benefits as if those individuals were the parents of the child.

3. Active Employee or retired or laid off Employee. The Plan that covers a person as an active Employee, that is, an Employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid off Employee is the Secondary Plan. The same would hold true if a person is a Dependent of an active Employee and that same person is a Dependent of a retired or laid off Employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an Employee, Covered Person, subscriber or retiree or covering the person as a Dependent of an Employee, Covered Person, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. Longer or shorter length of coverage. The Plan that covered the person as an Employee, Covered Person, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Calendar Year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health

care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more closed panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one closed panel Plan, COB shall not apply between that Plan and other closed panel Plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. Third Party Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Third Party Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, this Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. This Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by this Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If You believe that the Plan has not paid a claim properly, You should first attempt to resolve the problem by contacting the Customer Service Center at 330-363-6360 or 1-800-344-8858 or visit the Third Party Administrator’s website at www.aultcare.com.

ANNUAL REQUIREMENT

Each year, You will be required to fill out an Other Coverage Information Form (OCIF). This form confirms there have been no changes in any Covered Person’s status with regard to other Coverage. The OCIF needs to be filled out and returned promptly, as it may affect the processing of Your claims. If You have questions, please contact the AultCare Service Center at 330-363-6360 or for Covered Persons outside Stark County, 800-344-8858 and a Customer Service Representative will help You. You may also supply the requested information online at www.aultcare.com.

SUBROGATION

AGREEMENT

AultCare may pay for a benefit that results from an Injury or Illness for which another person, plan, program or insurance company may be liable and/or responsible for paying. Examples include (without limitation) payments from another person or entity, automobile insurance, other liability coverage, and other insurance You may have (called first-party insurance) which pays Your claim. If You receive payment from any source, You must pay AultCare back. AultCare's benefit under this Plan is excess to several types of other insurance which may provide coverage for medical expenses. Accepting AultCare's payment of a benefit means You agree to all terms.

WHAT IS SUBROGATION?

When AultCare pays You a benefit that another person, plan, program or insurance company may be responsible for, AultCare has the right to get back the benefit it paid. This is called subrogation. AultCare's subrogation rights go into effect when it pays for Covered Services. At that point, AultCare becomes subrogated to all rights for which You may be entitled to receive payment from any person or entity. AultCare's subrogated rights include any claim You have to receive payments from the person or entity who caused the Illness or Injury, that person's or entity's insurer, any "uninsured motorist," any "underinsured motorist," any "medical payments," any "no-fault" payment, and any other similar coverage provisions. It does not apply to automobile property damage recovery. AultCare's right of subrogation applies equally to all state, federal or common law claims of survivors, wrongful death, loss of companionship (called "consortium") and other similar claims. AultCare's right of subrogation will not exceed the amount of the benefit it paid or will pay to You**.**

AultCare's Subrogation right has "first priority" to any payment You receive. That means AultCare has a right to be repaid before anyone else, including You**,** any Injured party, any attorney, any person with a claim that arises out of, or results from, the Illness or Injury (called a "derivative claim"), and any other person or entity with a claim, right or lien on the payment. AultCare's subrogation right will not be reduced by the amount of any attorney fees or costs You or any other party incur (including, but not limited to, fees and costs You actually paid, as well as fees and costs for services performed which You or another party are responsible for paying) to receive a potential payment. Notwithstanding, if less than the full value of the tort action is recovered because of comparative negligence, diminishment due to a party's liability under sections 2307.22 to 2307.28 of the Revised Code, or by reason of the collectability of the full value of the claim for Injury, death or loss to You resulting from limited liability insurance or any other cause, AultCare's subrogation claim shall be diminished in the same proportion as Your interest is diminished. If a dispute regarding the distribution of the recovery in the tort action arises, either party may file an action to resolve the issue of the distribution of the recovery.

AultCare's right to subrogation applies even if You, any Injured party, anyone with a derivative claim, any attorney, or any other person or entity is not "made whole." That means AultCare has a right to be reimbursed for its payment, even though there may not be enough money to compensate You fully for Your loss, or You receive only partial payment for the loss.

REIMBURSEMENT

If You receive payment from any person or entity or through any coverage payment, You must hold that payment "in trust" for AultCare. That means even though You are holding onto a payment made to You, the amount of that payment equal to the benefit AultCare paid is not Yours to keep. That amount belongs to AultCare. You must pay back AultCare the amount equal to the benefit AultCare had paid within fourteen (14) calendar days from the date You received that payment. Because some or all of the payment You are holding belongs to AultCare, any payment You, any Injured party, any attorney or any other person or entity receives is subject to what is called a constructive trust, or equitable lien that AultCare has on that payment, so it may be reimbursed.

AultCare's right to be reimbursed continues, even if You use the payment to buy real estate, personal property, or other property. If AultCare is not timely reimbursed from any payment, it may reduce future payments for a benefit to You until it is paid back in full. AultCare's reimbursement right is first in priority to any payment received. It takes priority over You, any Injured party, any attorney, any person with a derivative claim, and any other person or entity with a claim, right or lien on the payment. AultCare's reimbursement right will not be reduced for any attorney fees or costs You or any other person incur to get a potential payment. You, any Injured party, any attorney or any other person or entity must pay any expenses, including attorney fees and court costs that AultCare incurs to enforce its reimbursement right.

AultCare's reimbursement right applies even if You, any Injured party, any person with a derivative claim, any attorney or any other person or entity are not "made whole," are not fully compensated, or You receive only partial payment for the loss.

OTHER INSURANCE

If a benefit for an Illness or Injury also is covered under medical payments, personal Injury protection, no-fault, and any other similar coverage provisions, then AultCare coverage may be secondary to the other collectable insurance coverage. AultCare may require You to make a claim for that benefit with the other collectable insurance.

YOUR COOPERATION

You, any Injured party, any attorney and any other person or entity must cooperate with AultCare in the subrogation, reimbursement and other insurance process. You, any Injured party, any attorney and any other person or entity must do whatever is necessary to let AultCare recover reimbursement when there is other insurance or liability. You, any Injured party, any attorney or any other person or entity must sign all documents to assign Your rights under this Section to AultCare.

AultCare may end coverage if You do not cooperate as explained in this Section. You must give AultCare any requested information within five (5) business days of its request. You must promptly notify AultCare of how, when and where an accident or incident resulting in personal Injury occurred. You must promptly give AultCare all information about the persons involved. You, any Injured party, any attorney or any other person or entity must cooperate with AultCare in the investigation, settlement and protection of AultCare's rights. You, any Injured party, any attorney or any other person or entity must send AultCare copies of any police report, notices or other papers received in connection with the accident or incident resulting in any Illness or Injury. You, any Injured party, any attorney or any other person or entity must not settle or compromise any claims, unless You notify AultCare in writing at least thirty (30) calendar days before the settlement or compromise, and AultCare agrees to the settlement or compromise in writing. You must complete, sign and return an accident questionnaire and/or subrogation agreement before the Plan can process Your claim for Covered Services. The Plan cannot pay Your claim until You return the accident questionnaire and/or subrogation agreement. Because a delay in returning the questionnaire and/or subrogation agreement may prejudice the Plan subrogation rights, Your failure to return a completed questionnaire and/or subrogation agreement within thirty (30) calendar days, will result in the denial of Your claim. Please contact the AultCare Service Center if You have questions.

DISCRETIONARY AUTHORITY

AultCare has discretionary authority to interpret and enforce the terms and conditions of the subrogation, reimbursement and other insurance provisions and to make determinations as to the amount that may be owed. That means that whenever AultCare makes a determination or interpretation, it will be final and conclusive within the Plan, so long as it is not arbitrary and capricious, subject to Your rights to commence an Internal Appeal or External Review under the terms of this Plan consistent with Ohio and federal law.

PLAN INFORMATION

CITY OF CANTON, REFERRED TO AS THE "EMPLOYER", HAS ESTABLISHED THE BENEFITS, RIGHTS AND PRIVILEGES, WHICH SHALL PERTAIN TO ITS ELIGIBLE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS, AS DEFINED. THESE BENEFITS ARE PROVIDED THROUGH THE GENERAL ASSETS OF THE EMPLOYER AND WILL BE REFERRED TO AS THE "PLAN".

EFFECTIVE DATE: The Effective Date of the amended Plan (original effective of the Plan) is February 1, 2002 and restated July 1, 2020.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR AND PROCEDURE FOR ALLOCATION OF RESPONSIBILITY: The Named Fiduciary, Designated Legal Agent and Plan Administrator is City of Canton who has the authority to control and manage the operation and administration of the Plan. Although the Plan Administrator has hired a Third Party Administrator to manage the day-to-day operations of the Plan, the Plan Administrator has the sole authority to amend the Plan, to determine its policies, to appoint and remove Third Party Administrators, and exercise general administrative authority over them. The Plan Administrator has the sole discretionary authority and responsibility to review and make final decisions on all claims to benefits according to the provisions of the Plan and, in the event that the item in question is not specifically addressed in the Plan, then the decision will be made by the Plan Administrator in accordance with its interpretation of the Plan.

BASIS ON WHICH PAYMENTS ARE TO BE MADE (CONTRIBUTIONS): The Employer pays for all costs related to the Plan solely out of its general assets; however, Employees are required to reimburse the Employer for a portion of those costs on the following basis.

Employee Dental Coverage:	Contributory
Dependent Dental Coverage:	Contributory
Employee Vision Coverage:	Contributory
Dependent Vision Coverage:	Contributory

The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Covered Employee.

FUNDING POLICY: Notwithstanding any other provision of the Plan, the Employer's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions as set forth in the preceding paragraph entitled "Basis on Which Payments are to be Made". In the event that the Employer terminates the Plan, then as of the Effective Date of termination, the Employer (and Covered Persons) shall have no further obligation to make additional contributions. In addition, coverage for allowable claims filed after such Plan termination date shall be limited to any remaining Employer contributions not required to pay claims filed before the effective Plan termination date.

PROTECTION AGAINST CREDITORS: No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Employer shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Employer at its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment, and in such case shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his spouse, parent, adult child, guardian of a minor child, brother, or sister, or other relative of a Dependent of such Covered Person or former Covered Person, as the Employer may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment.

PLAN AMENDMENTS: This document contains all the terms of the Plan and may be amended from time to time by the authorized person or persons designated by the Plan Administrator.

The Plan Administrator shall notify all Covered Persons of any Plan modifications or changes that constitute a "material reduction in Covered Services or benefits" no later than sixty (60) days of the date such changes or modifications become effective. Covered Persons will be notified of all other modifications or changes no later than 210 days after the close of the Plan Year in which the Amendment making such changes or modifications has been adopted. Such notifications shall be in the form of a Summary of Material Modifications unless incorporated in an updated Summary Plan Description.

TERMINATION OF PLAN: Although the Plan is meant to continue on an indefinite basis, the Employer reserves the right at any time to unilaterally terminate the Plan by a written instrument to that effect. All previous contributions by the Employer

shall continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to Claims arising before such termination, or shall be used for the purpose of providing similar benefits to Covered Persons, until all contributions are exhausted.

If the Plan is terminated, the Plan Administrator will notify all Covered Persons as soon as it is administratively feasible but no later than the date of termination unless due to reasons beyond the Plan Administrator's control.

If the Plan is terminated and if, for whatever reason, there are insufficient monies to fund the cost of benefits incurred prior to the date of termination, the Covered Person will be responsible for the cost of such benefits (his Claims) incurred prior to the date the Plan terminates.

TERMINATION BY DISSOLUTION, INSOLVENCY, BANKRUPTCY, MERGER, ETC.: This Plan shall automatically terminate if the Employer (1) is legally dissolved, (2) makes any general assignment for the benefit of its creditors, (3) files for liquidation under the Bankruptcy code, (4) merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the Company's successor in interest agrees to assume the liabilities under this Plan as to the Covered Persons.

PROTECTED HEALTH INFORMATION (PHI): Protected Health Information (PHI) is individually identifiable health information, including demographic information, which is collected, created or received by a health care provider, a health Plan, an Employer or a health care clearinghouse that relates to: Your past, present or future physical or mental health or condition; the provision of health care to You or; the past, present, or future payment of Claims for health care for You.

The Plan has been amended consistent with the applicable requirements of the § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, parts 160 through 164. Herein, it will be referred to as the "HIPAA Privacy Rule".

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule; the Plan designates the Plan Sponsor to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule, including entering into business associate contracts and accepting certification from the Plan Sponsor.

The Plan will disclose Protected Health Information (PHI) to the Plan Sponsor, or provide for or permit the disclosure of PHI to the Plan Sponsor by a health insurance issuer or HMO, but only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of the "HIPAA Privacy Rule", regarding the permitted and required uses and disclosure of Protected Health Information by the Plan Sponsor; the Plan Sponsor agrees to comply with the Plan provisions on PHI. The Plan must not disclose and must not permit the disclosure of PHI to the Plan Sponsor unless the certification has been signed.

Permitted Disclosure of Protected Health Information to the Plan Sponsor: Unless otherwise permitted by law and subject to obtaining the written certification discussed above, the Plan may disclose Protected Health Information (PHI) to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI for the permitted disclosures listed below:

1. The Plan (and any business associate acting on behalf of the Plan) will disclose PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out administrative functions on behalf of the Plan; such disclosure will be consistent with the provisions of the HIPAA Privacy Rule.

2. All disclosures of PHI by the Plan's business associate or health insurance issuer to the Plan Sponsor will comply with the HIPAA Privacy Rule.

3. The Plan (and any business associate acting on behalf of the Plan) may not disclose PHI to the Plan Sponsor for employment-related actions and decisions, or in connection with any other benefit or Employee benefit plan of the Plan Sponsor.

4. The Plan Sponsor will not use or further disclose PHI other than as described herein and permitted by the HIPAA Privacy Rule.

5. If the Plan (or the Plan's health insurance issuer) provides PHI to the Plan Sponsor, the Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides PHI, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.

6. The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor.

7. The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan Document (as amended) and in the HIPAA Privacy Rule, of which the Plan Sponsor becomes aware.

Disclosure of Protected Health Information by the Plan Sponsor: The Plan Sponsor agrees to the following conditions with respect to any Protected Health Information disclosed to it by the Plan; the Plan Sponsor will:

1. Make the PHI available to the Covered Person who is the subject of the PHI.

2. Make PHI available for Amendment and incorporate any such Amendments to the PHI in accordance with the HIPAA Privacy Rule.

3. Make and maintain an accounting of the disclosures of PHI, if the HIPAA Privacy Rule requires that it must account for such disclosures.

4. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

5. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and will not retain copies when such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

6. Ensure that the required adequate separation between the Plan and Plan Sponsor is established and maintained.

Disclosures of Summary Health Information and Enrollment/Disenrollment Information to the Plan Sponsor: The Plan may disclose summary health information to the Plan Sponsor, in accordance with the HIPAA Privacy Rule, if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from insurance companies or other health plans for providing health coverage under or on behalf of the Plan.

2. Modifying, amending or terminating the Plan.

Required Separation Between the Plan and the Plan Sponsor: In accordance with the HIPAA Privacy Rule, certain Employees, who are under the control of the Plan Sponsor, may be given access to PHI received from the Plan. **Classes Refer to Administrative Services Only Agreement.**

This list reflects the classes of Employees or job titles of individuals who receive PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of PHI in violation of, or noncompliance with, the HIPAA Privacy Rule.

The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (EPHI): This Plan is meant to comply with the applicable requirements of 45 C.F.R §164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information.

“Electronic Protected Health Information” (EPHI) has the meaning set forth in 45 C.F.R. §160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media. The Plan Sponsor is responsible for establishing and maintaining reasonable safeguards of Electronic Protected Health Information that is created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

The Plan Sponsor shall:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

2. Ensure that adequate separation, as required by 45 C.F.R. §164.504(f)(2)(iii) of the HIPAA Privacy Rule, is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

4. Agrees to report to the Plan, within a reasonable time after the Plan Sponsor becomes aware, of any successful Security Incident that results in the successful unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information. The Plan Sponsor shall report to the Plan any other unsuccessful Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

The term "Security Incidents" has the meaning set forth in 45 C.F.R. §164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

DEFINITIONS

THE FOLLOWING ARE DEFINITIONS OF TERMS THAT MAY BE USED IN THE WORDING OF THE PLAN DOCUMENT. THESE DEFINITIONS ARE NOT MEANT TO IMPLY COVERAGE UNDER ANY BENEFIT UNLESS SPECIFICALLY PROVIDED UNDER THE PLAN.

ADVERSE BENEFIT DETERMINATION: *"Adverse Benefit Determination"* of a Claim means any denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit for which a Claim must be submitted. An Adverse Benefit Determination includes a failure to cover an item or service because the item or service is determined to be Experimental or not Medically/Dentally Necessary or not appropriate.

ALLOWABLE EXPENSE: "*Allowable Expense*" means the expense for services that are Covered up to Usual, Customary and Reasonable (UCR) Charge.

AMENDMENT: *"Amendment"* means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator.

ANTERIOR TEETH: *"Anterior Teeth"* means the incisor and cuspid teeth. The teeth are located in front of the bicuspids (pre-molars).

BENEFIT YEAR: "Benefit Year" means that period for which Benefit payments for Covered Services under the Plan are available, subject to the Maximum Annual limit.

BUSINESS DAY: "Business Day" means normal hours of business, Monday through Friday, excluding holidays.

CALENDAR YEAR: "*Calendar Year*" means a period of 12 months; specifically, January 1 through December 31.

CLAIM FOR BENEFITS: *"Claim for Benefits"* means any request for a plan benefit or benefits, made by a Covered Person (or by an authorized representative of the Covered Person) that complies with the Plan's reasonable procedure for making benefit claims. A claim for group health benefits includes "Pre-Service" Care Claims and "Post-Service" Claims.

COBRA: *"COBRA"* means the Consolidated Omnibus Budget Reconciliation Act of 1985, which requires that the continuation of group insurance coverage be offered to members who lose their health insurance due to a qualifying act, as defined by the Act. COBRA coverage is also referred to as "Continuation" coverage.

COINSURANCE: *"Coinsurance"* means a percentage of Eligible Expenses that a Covered Person will pay (Cost Share) with the Plan, usually after the Deductible is met. (Refer to the Schedule of Benefits.)

COMPANY: "*Company"* means ***City of Canton***.

COPAYMENT: "*Copayment*" means the dollar amount or percentage of costs shown in the Benefits Chart that a Covered Person must pay directly to the Provider for certain Covered Services.

COST SHARE: *"Cost Share"* means the portion of the maximum allowed amount that You are required to pay. This includes Coinsurance, Deductible, and/or Copayments. This does not include premiums, amounts over UCR, or ineligible expenses.

COSMETIC SERVICES: *"Cosmetic Services"* means procedures or services that are cosmetic in nature.

COVERED DEPENDENT: "*Covered Dependent*" means any Dependent of an Employee meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

COVERED EMPLOYEE: "*Covered Employee*" means any Employee meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

COVERED PERSON: "*Covered Person*" means any Employee or Dependent of an Employee meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

COVERED SERVICES: "*Covered Services*" means treatments and services that are covered and not excluded from coverage under this Plan, subject to the terms, conditions, limitations, restrictions, and requirements of this Plan.

DEDUCTIBLE: "*Deductible"* means a specified dollar amount of Eligible Expenses which a Covered Person must pay (Cost Share) before any Eligible Expenses will be paid by the Plan. (Refer to the Schedule of Benefits).

DENTAL HYGIENIST: *"Dental Hygienist"* A person who has been trained in an accredited school; who is licensed by the state in which he is practicing the art of dental prophylaxis; and who is practicing under the direction and supervision of a Dentist.

DENTIST: *"Dentist"* means any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental service, perform dental surgery or administer anesthetics for dental surgery.

DEPENDENT: "*Dependent*" means those persons identified in the "Dependent Eligibility" section of this Plan Document as being eligible for coverage and who are enrolled in coverage.

ELIGIBLE EXPENSES: "*Eligible Expenses*" means expenses for Covered Services subject to the terms, conditions, limitations, restrictions, exclusions, and requirements, including cost sharing requirements, of this Plan. An expense is considered incurred at the time or date the Covered Dental Service is rendered; or the date the site is prepared.

ELIMINATION PERIOD: "Elimination Period" means a period of time, which You or Your Dependent must be covered under the Plan to be eligible for Covered Services.

EMERGENCY or EMERGENCY SERVICES: An "*Emergency" or "Emergency Services"* mean a dental condition or symptom resulting from dental disease which arises suddenly and is severe enough, in the judgment of a prudent layperson with an average knowledge of health and medicine, requires immediate care and treatment.

EMPLOYEE: "*Employee*" means a person directly employed in the regular business of, and compensated for services by the Employer.

EMPLOYER: "*Employer*" means City of Canton.

ENDODONTIC: "*Endodontic*" means the prevention, diagnosis and treatment of disease and Injuries that affect the tooth pulp.

ERISA: "*ERISA*" means the Employee Retirement Income Security Act of 1974 or any provision or section thereof which is herein specifically referred to, as such Act, provision or section as may be amended from time to time.

EXPERIMENTAL OR INVESTIGATIONAL: A Health Care Service (including a supply, device, drug, and dental service) is *"Experimental or Investigational"* if the Third Party Administrator determines that any of the following apply:

1. There are insufficient or inconclusive outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate the safety, effectiveness, or value of the proposed Service for the Illness, Injury or disease involved; or

2. Approval is required by the U. S. Food and Drug Administration (FDA), or other licensing or regulatory agency, for marketing or use and final approval has not been granted; or

3. A recognized national medical or dental society or regulatory agency has determined, in writing, that the Service is Experimental or Investigational, or for research purposes; or

4. The Service is a type of drug, device, procedure, or treatment that is the subject of a Phase I or Phase II clinical trial or the Experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or

5. The written protocol or protocols used by the treating facility or Provider, or the protocol or protocols of any other facility or Provider studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or Provider or by another facility or Provider studying the same drug, device, procedure, or treatment, states that the drug, device, procedure or treatment is Experimental or Investigational, or for research purposes; or

6. The Plan otherwise determines a Service is Experimental or Investigational based on Our consideration of scientific evidence, evidence of population health outcomes, effectiveness of established alternative services, published and peer-reviewed medical or scientific literature, evaluations of medical associations, consensus panels, or technology evaluation bodies, documents issued by or filed with regulatory agencies, written protocol(s) used by Providers, medical records, opinions of consulting Providers, or other relevant information.

The Third Party Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Service is Experimental or Investigative.

EXPLANATION OF BENEFITS (EOB): *"Explanation of Benefits*" means a statement that details Your Claim, including the services provided, the amounts paid and Your payment responsibility.

EXTERNAL REVIEW: "*External Review***"** means a review conducted pursuant to the External Review provisions of this Plan.

FAMILY: *"Family"* means a Covered Employee and his Covered Dependents.

FAMILY DEDUCTIBLE: "*Family Deductible"* means a Deductible that applies to Eligible Expenses incurred by a Family covered by this Plan before Eligible Expenses are payable by this Plan for any member of a Family, unless stated otherwise in the section entitled "Schedule of Dental Benefits".

FULL-TIME: *"Full-Time"* means working the minimum number of hours established by the Employer unless hired on a temporary or seasonal basis, as determined by the Employer.

HOSPITAL: "*Hospital"* means a Veterans Administration Hospital (when care or treatment is provided for non-service related Injury or Illness) or an institution which meets all of the following conditions:

1. It is licensed and operated in accordance with the laws of jurisdiction in which it is located which pertains to Hospitals; is engaged primarily in providing medical care and treatment to Ill and Injured persons on an Inpatient basis at the patient's expense; maintains on its premises all the facilities necessary to provide for diagnosis and medical and surgical treatment of an Illness or an Injury; and such treatment is provided by under the supervision of Physicians with continuous twenty-four (24) hour nursing services by registered nurses; and

2. It qualifies as a Hospital, an alcohol or drug abuse or psychiatric Hospital, or a tuberculosis Hospital and is accredited by CMS or by an authority deemed by CMS to be an accredited authority, including but not limited to The Joint Commission, the American Osteopathic Association, and DNV Healthcare, Inc.;

3. It is a provider of services under Medicare; and

4. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics or a nursing home.

The provisions shown above under items #2 and #3 do not apply when a Covered Person is visiting, traveling or temporarily residing in a foreign country and must be Hospitalized during such absence from the United States due to Medical/Dental Necessity. Charges for translation services are not covered under the Plan.

ILLNESS: "*Illness*" means a bodily disorder, disease, physical sickness, Mental and/or Nervous Disorder, or Alcohol and/or Drug Abuse. All such disorders existing simultaneously, which are due to the same or related causes, shall be considered one Illness.

IMPLANT: An '*Implant*" is a prosthetic tooth mounted to the bone with a screw.

IMPLANTOLOGY: *"Implantology"* refers to all services, supplies and surgeries related to an Implant.

INCURRED DATE: *"Incurred Date*" means the date treatment and services are rendered or seated.

INDEPENDENT REVIEW ORGANIZATION: "*Independent Review Organization*" or "*IRO*" means a person or entity that conducts an External Review with respect to an Adverse Benefit Determination.

INJURY: "*Injury*" means a condition caused by accidental means, which results in damage to the Covered Person's body from an external force. Any loss which is caused by or contributed to by hernia of any kind will be considered a loss under the definition of Illness, and not as a loss resulting from accidental Injury.

INPATIENT: "*Inpatient*" means the classification of a Covered Person when that Person is admitted to a Hospital, hospice, or convalescent facility for treatment, and charges are made for room and board to the Covered Person as a result of such treatment. A Covered Person is an Inpatient starting when the Person is formally admitted to the Hospital with a doctor's order.

INTERNAL APPEAL: "*Internal Appeal*" means an appeal conducted by the Plan, or the Plan Administrator when a Covered Person requests an Internal Appeal because of an Adverse Benefit Determination.

LIFETIME: Wherever the word "*Lifetime*" appears in this Plan in reference to benefit maximums and limitations, it is understood to mean, "while covered under this Plan". Under no circumstances does "*Lifetime*" mean during the lifetime of the Covered Person.

LIMITING AGE: ***"****Limiting Age"* means the age in which a person no longer is eligible as a Dependent, as shown in the eligibility section.

MALE PRONOUN: Use of the *"Male Pronoun"*, whenever used, includes the female.

MAXIMUM ANNUAL BENEFIT: *"Maximum Annual Benefit"* means the limit of Coverage during the Benefit Year that the Plan may pay.

MAXIMUM LIFETIME BENEFIT: *"Maximum Lifetime Benefit"* means the limit of Benefits a Covered Person may receive for certain designated Services of that Covered Person's lifetime. After a Maximum Lifetime Benefit is met, the Plan will not pay for additional services subject to the Maximum Lifetime Benefit while the Covered Person is covered under the Plan.

MEDICAID: "*Medicaid*" means the programs established by Title XIX of the Social Security Amendments of 1965 provides federally subsidized medical care for the poor. This is a cost-sharing program, with both federal and state governments sharing in the provision of benefits.

MEDICALLY/DENTALLY NECESSARY or MEDICAL/DENTAL NECESSITY: A Health Care Service (including a supply, device, drug, and dental service) is *"Medically/Dentally Necessary"* only if it is determined by Us to be:

1. For the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury or disease, or the symptom of an Illness, Injury or disease;

2. Obtained from a Provider;

3. Provided in accordance with accepted standards of medical or dental practice;

4. Clinically appropriate, in terms of type, frequency, supply, extent, site of care and duration of the Service as determined in accordance with Our therapeutic and site of care guidelines;

5. Not primarily for the convenience of the patient or Provider;

6. Cost effective as compared to Alternative Treatments or sequences of services that are at least as likely to produce the same therapeutic or diagnostic results;

7. Not Experimental or Investigational or Unproven; and

8. Not otherwise subject to an exclusion under this Plan.

As used in this Plan, "accepted standards of medical or dental practice" means standards that are (1) based on credible scientific evidence published in peer-reviewed literature and generally recognized by the relevant medical or dental community, (2) consistent with Physician or dental specialty society recommendations when applicable, and (3) consistent with the views of Physicians or Dentists practicing in relevant clinical areas and other relevant factors.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, Services or supplies does not, of itself, make such care, treatment, Services or supplies Medically/Dentally Necessary or a Covered Service and does not guarantee payment by the Third Party Administrator.

MEDICARE: "*Medicare*" means the programs established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled "Health Insurance for the Aged Act", and which includes Parts A and B and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79) as amended from time to time.

NETWORK PROVIDER/AFFILIATE: *"Network Provider/Affiliate"* means a provider of Covered Services that holds a valid Provider Agreement with the Plan or a Network under contract with the Plan Administrator and approved by the Plan.

NON-COVERED SERVICES: "*Non-Covered Services*" means treatment and services that are not covered or Eligible for payment of Benefits. The patient may be financially responsible for paying for Non-Covered Services.

NON-NETWORK PROVIDER/AFFILIATE: *"Non-Network Provider/Affiliate"* means a provider of Covered Services, including any Physician, Dentist, Dental Hygienist, or other health care Provide operating within the scope of his license who does not have a contract with the Plan.

ORTHODONTIC TREATMENT: "*Orthodontic Treatment*" *or "Orthodontia"* means the movement of one or more teeth by the use of active appliances. It includes: 1) Treatment Plan and records, including initial, interim and final records; 2) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; 3) orthodontic retention, including any and all Medically/Dentally Necessary fixed and removable appliances and related visits.

OUTPATIENT: "*Outpatient*" means the classification of a Covered Person when that Covered Person receives medical care, treatment, services or supplies at a clinic, a Physician's office, or at a Hospital or other facility when not a registered bed patient.

PANORAMIC X-RAY: "*Panoramic X-ray*" means an extraoral radiograph on which the maxilla and mandible are depicted on a single film

PERIODONTICS: The term *"Periodontics"* means the examination, diagnosis and treatment of diseases affecting the supporting and surrounding tissues of the teeth, including the gingiva, cementum, periodontal membrane and alveolar or supporting bone.

PHYSICIAN: *"Physician"* means a properly licensed individual who provides Covered Services. Physician shall include Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Surgical Chiropody (DSC), Doctor of Chiropractor (DC), Doctor of Podiatry (DPM), Psychologist (PhD), Psychiatrist (MD), Optometrist (OD), Ophthalmologist (MD) and any other licensed health care practitioner whom law requires be recognized as a Physician and who is operating within the scope of his license. Physician also means a licensed health care practitioner, who is legally licensed or certified, and within the scope of that license or certificate, is permitted to perform the services for which Benefits are provided under this Plan.

PLAN: *"Plan"* means, without qualification, the City of Canton Employee Dental & Vision Plan Document, the provisions of which are set forth in this Plan Document which may be amended from time to time. The term "Plan" is separately defined in the Coordination of Benefits Section to apply to COB, subrogation and right of recovery only.

PLAN ADMINISTRATOR: "*Plan Administrator*" means the Employer, who is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process Claims and perform other Plan connected services.

PLAN PARTICIPANT: *"Plan Participant"* means an Employee of the Employer stated in this Plan.

PLAN SPONSOR: *"Plan Sponsor"* means the City of Canton. The Plan Sponsor has established the Plan to provide benefits as described herein for Participating Employers and eligible Employees and their eligible Dependents.

PLAN YEAR: "*Plan Year*" means a period of time commencing with the Effective Date of this Plan or the Plan Anniversary, and terminating on the date of the next succeeding Plan Anniversary.

POST-SERVICE CLAIM: *"Post-Service Claim"* is any Claim for Benefits after the services have been rendered or incurred.

PREDETERMINATION: "*Predetermination"* is a review for any proposed item or service, including estimated costs, that may exceed a specified amount as set forth in this Plan.

PRE-SERVICE CLAIMS: "*Pre-Service Claim*" means the Prior Authorization of Plan benefits submitted prior to an item or service being incurred.

PRIMARY PLAN: "*Primary Plan*" means a plan that determines payment of its benefits first, before the benefits of any other plan, and without consideration of any other plan's benefits.

PRIOR AUTHORIZATION: "*Prior Authorization*" also known as Pre-Approval means a determination by our Utilization Management Department that a service has been reviewed and, based upon the information provided, the dental care Service satisfies the requirements for Benefit payment under this Plan.

PROVIDER: "*Provider*" means any Provider of Covered Services.

QUALIFIED BENEFICIARY: For purposes of COBRA, "*Qualified Beneficiary*" means a Covered Employee and/or the spouse or child of a Covered Employee, who on the date immediately before a qualifying event occurred, was covered for benefits under this Plan.

ROOT PLANING: "*Root Planing*" is a procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased cementum or dentin on the root surfaces and in the pocket.

SCALING: "*Scaling*" means removal of plaque, calculus and stain from teeth.

SCHEDULE OF BENEFITS: "Schedule of Dental Benefits" means the information provided concerning the limits, maximums and specific details about Your Benefits Plan and Deductible and Coinsurance amounts You must pay.

SECONDARY PLAN: "*Secondary Plan*" means a plan that determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits will not exceed the Secondary Plan's normal liability when combined with the Primary Plan's payment.

TREATMENT PLAN: "*Treatment Plan*" is an estimate of the treatment(s) associated with a proposed service.

THIRD PARTY ADMINISTRATOR: "*Third Party Administrator*" means the person or firm employed by the Plan Administrator who is responsible for the processing of Claims and payment of benefits, administration, accounting, reports and other services contracted for by the Plan Administrator. The Third Party Administrator for this Plan is AultCare.

UNPROVEN: 'Unproven' means a Health Care Service (including a supply, device, drug, medical or dental service) is "Unproven" if the Third Party Administrator determines that any of the following apply:

1. The Service is determined not to be effective for treatment of the medical or dental condition; or,

2. There is insufficient or inconclusive clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature of which the sample size is of sufficient power to substantiate a beneficial effect on net health outcomes over time for the given indication, and the majority of providers practicing in the appropriate medical or dental specialty recognize the treatment or service to be safe and effective in treating the medical or dental condition for which it is intended.

USUAL, CUSTOMARY AND REASONABLE (UCR): "*UCR"* means allowable fees for Covered Services. For Network Providers, UCR means the professional fees the Plan has negotiated with them. For Non-Network Providers, UCR means a fee level that the Plan has determined to be appropriate for a particular medical or dental service, which often is less than the Providers actually charge. The Plan will not pay that portion of Non-Network Provider fees that exceeds UCR. You may be responsible for paying that amount.

WAITING PERIOD: "*Waiting Period*" means the length of time established by this Plan immediately before Your coverage can become effective during which You must be an eligible Employee.

YOU: *"You"* means a Covered Person, or an authorized representative of a Covered Person in appropriate circumstances.

GENERAL PROVISIONS

LEGAL PROCEEDINGS: No action at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

TIME LIMITATION: If any time limitations of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of any action at law or in equity, is less than that permitted by any law to which it is subject, such limitation is hereby extended to agree with the minimum period permitted by such law.

CLERICAL ERROR: Clerical error (whether by the Employer, Plan Administrator or the Third Party Administrator) in keeping the records having to do with this Plan, or delays in making entries on the records, will not void or reduce the coverage of any person if that coverage would otherwise have been in effect or not reduced. Such clerical error will not extend the coverage of any person if that coverage would otherwise have ended or been reduced as provided by this Plan Document.

PROVIDER ACTS OR OMISSIONS: The Plan Administrator and/or Third Party Administrator is not responsible for the quality of care You receive from any person or facility. The Plan does not give anyone any claim, right or cause of action against the Employer, Plan Administrator or Third Party Administrator based on what a Provider of health care, or supplies, does or does not do. This applies whether such Provider is a Network Provider or not.

FREE CHOICE OF PHYSICIANS: The Covered Person shall have free choice of any legally qualified Physician or surgeon and the Physician-patient relationship shall be maintained. At any time, the Covered Person may choose a Network Provider or any other Provider who is qualified as defined in the Plan. The benefits shown in the Schedule of Benefits for "Network", however, shall apply only to the services and supplies that are furnished directly by a Network Provider unless otherwise shown in the Schedule of Benefits.

WORKERS' COMPENSATION NOT AFFECTED: This Plan is not a Workers' Compensation policy and is not issued in lieu thereof. The Plan does not satisfy any requirements for coverage by Workers' Compensation Insurance.

This Plan does not cover:

1. Charges covered under any Workers' Compensation Law or similar law.

2. Injuries at work if Workers' Compensation is available, required, or applicable, regardless of whether a Workers' Compensation Claim is filed.

3. Charges for You, Your Dependents or Spouse for a work related Injury while self-employed.

CONFORMITY WITH LAW: If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

STATEMENTS: In the absence of fraud, all statements made by a Covered Person will be deemed representative and not warranties. No such representation will void the Plan Benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

MISCELLANEOUS: Section titles are for convenience of reference only, and are not to be considered in interpreting the Plan. No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Plan.

PLAN IS NOT A CONTRACT: The Plan shall not be deemed to constitute a contract between the Plan Administrator and any person or to be a consideration for, or an inducement or condition of, the employment of any person. Nothing in the Plan shall be deemed to give any person the right to be retained in the service of the Plan Administrator or to interfere with the right of the Plan Administrator to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Administrator with the bargaining representative of any Employee.

RIGHTS OF PARTICIPANTS: As a Participant under this Plan, You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts and collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 Series), if applicable, filed with the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series), if applicable, and copies of the updated summary plan description. The Plan Administrator may make a reasonable charge for the copies. The Plan does not release any plan governing documents to third parties (i.e. Providers, legal representatives, etc.) unless requested through court order.

If the Plan Administrator is required to do so by law, to furnish each Participant with a copy of a summary financial report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage under the Plan for Yourself, Your spouse or Your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Refer to the section entitled "Continuation of Coverage (COBRA)" for information on Your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the persons responsible for the operation of the benefit Plan. The persons who operate Your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of You and other Plan Participants and beneficiaries. No one, including Your Employer, Your union (if applicable), or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a benefit under the Plan or exercising Your rights under ERISA.

ENFORCE YOUR RIGHTS

If Your claim for a benefit under this Plan is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of the Plan documents or the latest annual report (if applicable) from the Plan and do not receive them within thirty (30) days, You may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If You have a Claim for Benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that the Plan Fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If You are successful in Your lawsuit, the court may require the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.