CITY OF CANTON

EMPLOYEE HEALTH CARE PLAN

AFSCME
FIRE
FOP
NON-BARGAINING
POLICE CPPA BARGAINING

PLAN DOCUMENT
&
SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE
02/01/2020

AULTCARE

TABLE OF CONTENTS

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 Health Care Plan
Type of Plan	Self-Funded Medical and Pharmacy 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 Self-Funded Effective Date	February 1, 1995
Effective Date of Restated Plan (AultCare's Date)	February 1, 2020
Plan Year	February 1st through January 31st
Group Number	21865M
Employer Identification Number	34-6000504
Plan Number	501

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

BARGAINING PLAN

	Retail 1-30 day supply	Retail 31-90 day supply	Mail Order
Generic:	$5.00 Copayment	$15.00 Copayment	$10.00 Copayment
Preferred:	$20.00 Copayment	$60.00 Copayment	$40.00 Copayment
Non-Preferred:	$35.00 Copayment	$105.00 Copayment	$70.00 Copayment

There is a combined Medical/Prescription Out-of-Pocket Maximum of $1,350 per Covered Person / $2,700 per Family. Once You have satisfied the combined Medical/Prescription Out-of-Pocket Maximum, there is an additional Prescription Out-of-Pocket Maximum of $5,000 per Covered Person / $10,000 per Family. Once You have satisfied the additional $5,000 per Covered Person / $10,000 per Family, Prescription Covered Services are payable at 100% for the remainder of the Calendar Year.

Up to a ninety (90)-day supply is available at the retail pharmacy. A ninety (90)-day supply may be obtained through the Mail Order Program.

ADDITIONAL PRESCRIPTION DRUG PLAN SPECIFICATIONS

NETWORK PHARMACIES

You can enjoy the convenience of local and national pharmacy service at discount network pricing. Please remember to present Your card at the pharmacy for Your prescriptions. If You didn't use Your member ID card for a prescription allowed by Your Plan, You can submit a claim for reimbursement. Your reimbursement claim will be considered based on Your Plan allowable amount. AultCare will reimburse up to the maximum amount AultCare would pay if You used Your ID card. For a pharmacy listing, please visit the AultCare website or contact the AultCare Customer Service Center.

GENERIC VS. BRAND

A Generic Medication will be dispensed when available. However, if You or Your Physician request that Brand Name Drug be dispensed, You will be responsible for the difference between the maximum allowable cost of the Generic and the Brand Name Drug. This penalty is not Covered by Your Plan, and these expenses will not count toward Your Deductible or Out-of-Pocket limit.

FORMULARY

Whenever it is Necessary to utilize a Brand Name Drug, please refer to the AultCare Formulary. The Brand Name Drugs contained on the Formulary have been found to be as effective as other medications in their class. By using a Formulary (Preferred) Brand Name Drug, You will realize a greater benefit than if You use a non-formulary (Non-Preferred) Brand Name Drug. AultCare offers Covered Persons an open Formulary design (which means that the Health Plan may cover the costs of drugs that are not on the Formulary list). Therefore, tier exceptions are not applicable. For example, a higher tier (Non-Preferred) medication may not be requested at a lower tier (Preferred) Copayment.

LONG-TERM ONGOING PRESCRIPTIONS

For long-term ongoing prescription drug needs, You can receive up to a ninety (90)-day supply through Your Mail Order Program. When participating in the Mail Order Program, You pay the appropriate mail order Copayment. The mail order pharmacy must fill Your prescription for the exact quantity of medications prescribed by Your doctor, up to the ninety (90)-day Plan limit. "Thirty (30)-days plus two (2) refills" does not equal one prescription written for "ninety (90)-days".

Visit AultCare's website at www.aultcare.com to view Your personalized prescription information. It gives valuable information to help You make informed decisions about Your drug purchase. Call the AultCare Customer Service Center at 330-363-6360 or 1-800-344-8858 for any questions regarding this process.

SPECIALTY MEDICATIONS

Specialty Medications are treatments for chronic Illnesses that require special handling techniques, careful administration, and a unique ordering process. These Medications must be obtained through a specialty network pharmacy. For information regarding these pharmacies and a list of specialty Medications, please visit the AultCare website at www.aultcare.com or You may call the AultCare Customer Service Center at 330-363-6360 or 1-800-344-8858.

STEP THERAPY PROGRAM

Your Plan currently requires Step Therapy for certain classes of medications. Step Therapy requires You to have tried a Step One (1) medication from the same therapeutic class as the Step Two (2) medication. If Your prescription history does not indicate that a Step One (1) medication was tried, the Step Two (2) medication will not be covered. Please note that the Step Two (2) medication will be covered at the appropriate benefit level once a Step One (1) medication has been tried and found to be ineffective. For a complete list of the Therapeutic categories and medications on the Step Therapy Program, please visit the Plan's website at www.aultcare.com or if You would like a paper copy, You may call the AultCare Customer Service Center at 330-363-6360 or 1-800-344-8858.

HEALTH CARE REFORM/PREVENTIVE CARE GUIDELINES

In response to the Patient Protection and Affordable Care Act and Preventive Care Guidelines, certain Medications will be covered at 100%, with no cost to You.

In order to receive a Medication at no cost, the following criteria must be met as it applies to You:

- Obtain a written prescription from Your Physician, even if Over-the-counter.
- If a Generic version is available, the Generic version will be covered at no cost to You; however, the Brand version will be subject to Your Plan's Cost Sharing.
- If a Generic version is not available, the Name Brand will be covered at 100%.
- If You are unable to take a Generic version, Prior Authorization is required for the Name Brand Medication. If approved, the Name Brand will be covered at 100%.

PRESCRIPTION DRUG PLAN COVERED SERVICES

- Drugs approved by the U.S. Food and Drug Administration (FDA) and that are required by federal or state laws to be dispensed to the public only on prescription of a licensed Physician or other licensed provider.
- Compound medication - The primary ingredient must be an FDA approved medications and not deemed Experimental and or Investigational.
- Diabetic supplies: including control solution, glucose test strips, urine test strips, acetone test strips, lancet devices, and lancets
- Insulin (prescription only), Insulin syringes/needles (prescription only)
- Injectable medications
- Over-the-counter medications required under Health Care Reform/Preventive Care Guidelines
- Tobacco cessation medications, aids, and devices required under Health Care Reform/Preventive Care Guidelines
- Contraceptive medications, Injectables, and devices
- Impotence Medications – limit to six (6) tabs per thirty (30)-day supply
- Migraine medications
- Prenatal vitamins
- Immunosuppressives
- Vaccines – Flu, Pneumonia, & Shingles are covered at 100% at the pharmacy. The Shingles vaccine is available for enrollees age fifty (50) years or older.
- FreeStyle Libre Sensor and Reader

SERVICES NOT COVERED BY THE PRESCRIPTION DRUG PLAN

- Lost, Stolen, or Damaged medications
- Experimental, Investigation or Unproven drugs
- Drugs obtained from pharmacies not located in the United States.
- Charges incurred outside the United States if the Covered Person traveled to such location for the sole purpose of obtaining a drug.
- Blood or Plasma
- Therapeutic devices or appliances, including support garments and other non-medical substances, unless otherwise specified.
- Charges for injections or administration of a drug
- A prescription that may be received without charge under Workers' Compensation Laws or other local, state, or federal programs. This would include medications taken for occupational Injury/disease.
- Prescriptions that are not self-administered or medication that is to be taken or administered to an Individual in a licensed Hospital, Skilled Nursing Facility, Physician's office/clinic or similar institution where such medications are normally provided by the facility on an Inpatient basis.
- Prescription refills in excess of the number specified or dispensed more than one (1) year from the date of the original order.
- Needles and syringes, other than for insulin
- Durable Medical Equipment including glucose monitors
- Over-the-counter medications, except for Insulin and Loratadine. All medications required under Health Care Reform/Preventive Care Guidelines are covered.
- Medical supplies except for Diabetic supplies
- Fertility medications
- Drugs for Cosmetic purposes only
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- Immunizing agents, Allergy Sera, and Biological Sera
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- Medicinal Foods
- Medical Devices

When this Plan is the Secondary Plan, You will be required to file prescription expenses with the Primary Plan first, and then submit to this Plan for secondary payment.

If coverage under Your Medical Plan terminates, Your prescription drug benefit will also terminate. If a Covered Person continues to use his or her prescription drug benefit, he or she will be held responsible for payment of any bills on or after the termination date.

Certain Medications may be covered under Your Medical Plan, require Precertification, have Step Therapy, and/or may have Plan limitations. Please visit the Third Party Administrator's website at www.aultcare.com to view Your personalized prescription information, or call the Customer Service Center at 330-363-6360 or 1-800-344-8858 for a listing of Medications or for any questions regarding this process.

To view options regarding opioid education, disposal sites, and educational material, visit the Pharmacy page on the AultCare website at www.aultcare.com. Education material is also available by clicking the link available on the website: https://www.cdc.gov/drugoverdose/patients/materials.html. Covered Persons will also receive patient focused educational material on opioid therapy at the pharmacy.

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- Charges for injections or administration of a drug
- A prescription that may be received without charge under Workers' Compensation Laws or other local, state, or federal programs. This would include medications taken for occupational Injury/disease.
- Prescriptions that are not self-administered or medication that is to be taken or administered to an Individual in a licensed Hospital, Skilled Nursing Facility, Physician's office/clinic or similar institution where such medications are normally provided by the facility on an Inpatient basis.
- Prescription refills in excess of the number specified or dispensed more than one (1) year from the date of the original order.
- Needles and syringes, other than for insulin
- Durable Medical Equipment including glucose monitors
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DESCRIPTION OF PRESCRIPTION DRUG BENEFITS

(PRESCRIPTION DRUG MANAGEMENT)

Payment for eligible prescription drug charges are paid at 100% after the Maximum Out-of-Pocket is satisfied for prescriptions purchased at a Network Pharmacy or through the Mail Order Program.

The Mail Order Program reduces the cost of maintenance Medications for both Plan Sponsors and their participants, while offering greater convenience to each. Participants can receive up to a ninety (90)-day supply through the Mail Order Program. When participating in the Mail Order Program, You pay the appropriate Copayment per ninety (90)-day supply. The mail order pharmacy must fill Your prescription for the exact quantity prescribed by Your Physician, up to the ninety (90)-day Plan limit.

Certain Medications may be covered under the medical benefit, require Precertification and/or may have Plan limitations. Please call the Customer Service Center at 330-363-6360 or 1-800-344-8858, if You have questions or if You need a pharmacy listing.

Third Party Administrator shall have no obligation to pay, and Plan Sponsor and Covered Persons shall have no right to receive, any rebates or any portion of rebates that Third Party Administrator may receive related to utilization of pharmacy benefits, other than as expressly agreed to in writing by Third Party Administrator and Plan Sponsor.

SCHEDULE OF MEDICAL BENEFITS - AFSCME

MEDICAL BENEFITS	NETWORK	NON-NETWORK
Lifetime Maximum	**UNLIMITED**	**UNLIMITED**
Annual Plan Maximum	**None**	**None**
Calendar Year Deductible per Individual	**$350**	**$350**
Calendar Year Deductible per Family	**$700**	**$700**
Maximum Out-of-Pocket per Individual	**$1,350**	**$2,350**
Maximum Out-of-Pocket per Family	**$2,700**	**$4,700**
The Deductible and Out-of-Pocket amounts are Embedded.		
The Plan include last quarter Individual and Family Deductible Carryover.		
The Network and Non-Network Deductibles and Out-of-Pocket amounts are Integrated.		
Amounts spent toward the Calendar Year Deductible count toward the Out-of-Pocket Maximum.		
-Note: Once You have satisfied the combined Medical/Prescription Out-of-Pocket Maximum, there are additional prescription Out-of-Pocket amounts.		
Prescription Out-of-Pocket - Individual	$5,000[7]	
Prescription Out-of-Pocket - Family	$10,000[7]	
--Note: There is a combined Medical/Prescription Out-of-Pocket Maximum of $1,350 per Covered Person / $2,700 per Family. Once You have satisfied the combined Medical/Prescription Out-of-Pocket Maximum, there is an additional prescription Out-of-Pocket Maximum of $5,000 per Covered Person / $10,000 per Family. Once You have satisfied the additional $5,000 per Covered Person / $10,000 per Family, prescription Covered Services are payable at 100% for the remainder of the Calendar Year		
Inpatient Hospital Care		
Semi-Private Room	**80%[1]**	**70%[2]**
Surgery	**80%[1]**	**70%[2]**
Physician	**80%[1]**	**70%[2]**
Ancillary Services	**80%[1]**	**70%[2]**
Outpatient Services		
Emergency Room (Emergent)	**100%**	**100%[6]**
- Copayment	**$200**	**$200**
-- The Copayment is waived if Covered Person is admitted.		
Urgent Care Facility (Emergent)	**80%[1]**	**80%[1,6]**
Same-Day Surgery	**80%[1]**	**70%[2]**
Nursing Services		
Home Health Care Services (Utilization Management approval required)	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Visits	100	
Hospice Care (Utilization Management Approval required)	**80%[1]**	**80%[2]**
Bereavement Counseling is a Covered Service.		
Private Duty Nursing – (Utilization Management approval required)	**80%[1]**	**70%[2]**

Skilled Nursing Facility (Utilization Management approval required)	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Day Limit	120	
Other Services		
Allergy Test	**80%[1]**	**70%[2]**
Allergy Extract	**80%[1]**	**70%[2]**
Allergy Injections	**80%[1]**	**70%[2]**
Ambulance	**80%[1]**	**80%[1,6]**
Diagnostic Testing/Laboratory/X-ray – Outpatient & Office	**80%[1]**	**70%[2]**
Durable Medical Equipment	**80%[1]**	**70%[2]**
Diabetic Supplies not covered under the Prescription Plan are covered under the Medical Plan.		
Diabetic Supplies	**80%[1]**	**70%[2]**
Orthotics	**80%[1]**	**70%[2]**
Wigs are a Covered Expense. Refer to Durable Medical Equipment benefit.		
- Note: Wig coverage is limited to the first wig following cancer treatment or alopecia related to a medical condition.		
Infertility Testing – Office & Outpatient	**80%[1]**	**70%[2]**
Infertility Treatment coverage is based on services rendered.		
- Note: Infertility treatment coverage is limited to treatment of medical condition only.		
Maternity Care coverage is based on services rendered.		
Pre-Admission Testing	**80%[1]**	**70%[2]**
Second Surgical Opinion coverage is based on services rendered.		
Care in the Physician's Office		
Primary Care Visits for Illness & Injury	**80%[1]**	**70%[2]**
Specialist Visit for Illness & Injury	**80%[1]**	**70%[2]**
Surgery	**80%[1]**	**70%[2]**
Therapy Services		
Cardiac Rehab Inpatient (Phase I)	**80%[1]**	**70%[2]**
Cardiac Rehab Outpatient (Phase II)	**80%[1]**	**70%[2]**
Chemo and Radiation Therapy – Outpatient & Office	**80%[1]**	**70%[2]**
Manipulation Therapy	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Manipulation Therapy limit	30	
Occupational Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Physical Therapy (Illness/Injury Related) – Inpatient	**80%[1]**	**70%[2]**
Physical Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Rehabilitative Therapy - Inpatient	**80%[1]**	**70%[2]**
Respiratory Therapy – Outpatient & Office	**80%[1]**	**70%[2]**
Speech Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**

Preventive Care

Well Baby/Child Care	**100%**	**70%[2]**
Immunizations are included in Well Baby/Child Care.		
- Age limitation (through age in years)	20	
-- Note: Services for Well Baby/Child Care include, but are not limited to, the Physician's office visit charge and related test, lab work and Immunizations. These Covered Network Services will be paid at 100% unless the Well Baby/Child Care is not defined as a Preventive Health Service.		
Routine Hearing Exam	**100%**	**70%[2]**
- Accumulation Type	See Note	
-- Dollar Maximum	$3,000	
--- Note: Audiology exam, fitting and hearing aids are covered up to a maximum of $3,000, per every four (4) years.		
Hearing Aid	**100%**	**70%[2]**
- Accumulation Type	See Note	
-- Dollar Maximum	$3,000	
--- Note: Audiology exam, fitting and hearing aids are covered up to a maximum of $3,000, per every four (4) years.		
Routine Physical Exam	**100%**	**70%[2]**
- Other Services(i.e. preventive screening	100%	70%[2]
-- Accumulation Type	Calendar Year	
---Visits	1	
---- Note: Covered Services for a routine physical include, but are not limited to, the Physician's office visit charge and related tests, X-rays, routine cancer screenings, routine mammograms, routine gynecological exam, routine pap test/smear, age and gender appropriate screening, routine prostate screening, lab work and Immunizations. These Network services will be paid at 100% unless the routine physical is not defined as a Preventive Health Service.		
Routine Prostate/PSA Screening	**100%**	**70%[2]**
Routine Gynecological Exam	**100%**	**70%[2]**
Routine Pap Test/Smear	**100%**	**70%[2]**
Routine Immunizations	**100%**	**70%[2]**
Routine Mammograms	**100%**	**70%[2]**
Routine Colonoscopy	**100%**	**70%[2]**

Mental Health and/or Substance Abuse

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA):		
Inpatient care will be paid the same as any other Inpatient stay.		
Please refer to Inpatient Hospital for benefit level.		
In lieu of an Inpatient stay, Outpatient care (including a partial Hospital or intensive Outpatient program) will be paid the same as any other Outpatient service.	**80%[1,3]**	**70%[2,3]**

Additional Information

Precertification may be required.

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

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 service, which often is less than the Providers actually charge. The Plan will not pay that portion of Non-Network Provider fees that exceeds Usual, Customary and Reasonable (UCR). You may be responsible for paying that amount.

[1]A Calendar Year Deductible of $350 per Covered Person/$700 per Family is applied first before any Covered Services are paid to Network Providers, and designated Covered Services to Non-Network Providers. Deductible, medical and prescription Copayments and Coinsurance are subject to an Out-of-Pocket Maximum of $1,350 per Covered Person/$2,700 per Family. Once You have met this maximum, the Plan begins to pay medical Covered Services at 100%, except for penalties which are not included in the 100% reimbursement provision.

[2]A Calendar Year Deductible of $350 per Covered Person / $700 per Family is applied first before Covered Services are paid to Non-Network Providers. Payments to Non-Network Provider for Covered Services are based on Usual, Customary and Reasonable criteria (UCR). Deductible, and Coinsurance are subject to an Out-of-Pocket Maximum of $2,350 per Covered Person / $4,700 per Family. Once You have met this maximum, the Plan begins to pay medical Covered Services at 100% UCR, except for penalties which are not included in the 100% reimbursement provision.

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

[4]Deductible does not apply to this benefit. Coinsurance and Copayments are subject to an Out of Pocket Maximum of $1,350 per Person/$2,700 per Family. Once You have met this maximum, the Plan begins to pay Medical Covered Services at 100%.

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

[6]Payments to Non-Network Providers for Covered Services are based on Usual, Customary, and Reasonable criteria (UCR). Charges for Non-Network Provider Covered Services that exceed the UCR may be Your responsibility.

[7]There is a combined Medical/Prescription Out-of-Pocket Maximum of $1,350 per Covered Person / $2,700 per Family. Once You have satisfied the combined medical/prescription Out-of-Pocket Maximum there is an additional prescription Out-of-Pocket Maximum of $5,000 per Covered Person / $10,000 per Family. Once You have satisfied the additional $5,000 per Covered Person / $10,000 per Family, prescription Covered Services are payable at 100% for the remainder of the Calendar Year.

SCHEDULE OF MEDICAL BENEFITS - FIRE

MEDICAL BENEFITS	NETWORK	NON-NETWORK
Lifetime Maximum	**UNLIMITED**	**UNLIMITED**
Annual Plan Maximum	**None**	**None**
Calendar Year Deductible per Individual	**$350**	**$350**
Calendar Year Deductible per Family	**$700**	**$700**
Maximum Out-of-Pocket per Individual	**$1,350**	**$2,350**
Maximum Out-of-Pocket per Family	**$2,700**	**$4,700**
The Deductible and Out-of-Pocket amounts are Embedded.		
The Plan includes last quarter Individual and Family Deductible Carryover.		
The Network and Non-Network Deductibles and Out-of-Pocket amounts are Integrated.		
Amounts spent toward the Calendar Year Deductible count toward the Out-of-Pocket Maximum.		
- Note: Once You have satisfied the combined medical/prescription Out-of-Pocket Maximum, there are additional prescription Out-of-Pocket amounts.		
Amounts spent toward Prescription Drugs count toward the Out-of-Pocket Maximum.		
Prescription Out-of-Pocket - Individual	$5,000[7]	
Prescription Out-of-Pocket - Family	$10,000[7]	
- Note: There is a combined Medical/Prescription Out-of-Pocket Maximum of $1,350 per Covered Person / $2,700 per Family. Once You have satisfied the combined Medical/Prescription Out-of-Pocket Maximum, there is an additional Prescription Out-of-Pocket Maximum of $5,000 per Covered Person / $10,000 per Family. Once You have satisfied the additional $5,000 per Covered Person / $10,000 per Family, prescription Covered Services are payable at 100% for the remainder of the Calendar Year.		
Inpatient Hospital Care		
Semi-Private Room	**80%[1]**	**70%[2]**
Surgery	**80%[1]**	**70%[2]**
Physician	**80%[1]**	**70%[2]**
Ancillary Services	**80%[1]**	**70%[2]**
Outpatient Services		
Emergency Room (Emergent)	**100%**	**100%[6]**
- Copayment	$200	$200
-- The Copayment is waived if the Covered Person is admitted.		
Urgent Care Facility (Emergent)	**80%[1]**	**80%[1,6]**
Same Day Surgery	**80%[1]**	**70%[2]**
Nursing Services		
Home Health Care Services (Utilization Management approval required)	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Visit limit	100	
Hospice Care (Utilization Management approval required)	**80%[1]**	**80%[2]**
Bereavement Counseling is a Covered Service.		
Private Duty Nursing - (Utilization Management approval required)	**80%[1]**	**70%[2]**

Skilled Nursing Facility (Utilization Management approval required)	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Day limit	120	
Other Services		
Allergy Tests	**80%[1]**	**70%[2]**
Allergy Extract	**80%[1]**	**70%[2]**
Allergy Injections	**80%[1]**	**70%[2]**
Ambulance	**80%[1]**	**80%[1,6]**
Diagnostic Testing/Laboratory/X-Ray – Outpatient & Office	**80%[1]**	**70%[2]**
Durable Medical Equipment	**80%[1]**	**70%[2]**
Diabetic Supplies not covered under the Prescription Plan are covered under the Medical Plan.		
Diabetic Supplies	80%[1]	70%[2]
Orthotics	**80%[1]**	**70%[2]**
Wigs are a Covered Expense. Refer to Durable Medical Equipment benefit.		
- Note: First wig following cancer treatment or alopecia related to a medical condition.		
Infertility Testing – Office & Outpatient	**80%[1]**	**70%[2]**
Infertility Treatment coverage is based on services rendered.		
- Note: Coverage limited to treatment of medical conditions only.		
Maternity Care coverage is based on services rendered.		
Pre-Admission Testing	**80%[1]**	**70%[2]**
Second Surgical Opinion coverage is based on services rendered.		
Care in the Physician's Office		
Primary Care Visit for Illness & Injury	**80%[1]**	**70%[2]**
Specialist Visit for Illness & Injury	**80%[1]**	**70%[2]**
Surgery	**80%[1]**	**70%[2]**
Therapy Services		
Cardiac Rehab Inpatient (Phase I)	**80%[1]**	**70%[2]**
Cardiac Rehab Outpatient (Phase II)	**80%[1]**	**70%[2]**
Chemo and Radiation Therapy – Outpatient & Office	**80%[1]**	**70%[2]**
Manipulation Therapy	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Manipulation Therapy limit	30	
Occupational Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Physical Therapy (Illness/Injury Related) - Inpatient	**80%[1]**	**70%[2]**
Physical Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Rehabilitative Therapy - Inpatient	**80%[1]**	**70%[2]**
Respiratory Therapy – Outpatient & Office	**80%[1]**	**70%[2]**
Speech Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**

Preventive Care		
Well Baby/Child Care	**100%**	**70%[2]**
Immunizations are included in Well Baby/Child Care.		
- Age limitation (through age)	20	
-- Note: Services for Well Baby/Child Care include, but are not limited to, the Physician's office visit charge and related tests, lab work and immunizations. These Covered Network Services will be paid at 100% unless the Well Baby/Child Care is not defined as a Preventive Health Service.		
Routine Hearing Exam	**100%**	**70%[2]**
- Accumulation Type:	See Note	
-- Dollars Maximum	$3,000	
--- Note: Audiology exam, fitting and hearing aids are covered up to a maximum of $3,000, per every four (4) years.		
Hearing Aid	**100%**	**70%[2]**
- Accumulation Type	See Note	
-- Dollars Maximum	$3.000	
--- Note: Audiology exam, fitting and hearing aids are covered up to a maximum of $3,000, per every four (4) years.		
Routine Physical Exam	**100%**	**70%[2]**
- Other Services (i.e. preventive screenings)	100%	70%[2]
-- Accumulation Type	Calendar Year	
--- Visits	1	
---- Note: Covered Services for a routine physical include, but are not limited to, the Physician's office visit charge and related tests, X-rays, routine cancer screenings, routine mammograms, routine gynecological exam, routine pap test/smear, age and gender appropriate screening, routine prostate screening, lab work and immunizations. These Network services will be paid at 100% unless the routine physical is not defined as a Preventive Health Service.		
Routine Prostate/PSA Screening	**100%**	**70%[2]**
Routine Gynecological Exam	**100%**	**70%[2]**
Routine Pap Test/Smear	**100%**	**70%[2]**
Routine Immunizations	**100%**	**70%[2]**
Routine Mammograms	**100%**	**70%[2]**
Routine Colonoscopy	**100%**	**70%[2]**

Mental Health and /or Substance Abuse		
Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA):		
Inpatient care will be paid the same as any other Inpatient stay.		
Please refer to Inpatient Hospital for benefit level.		
In lieu of an Inpatient stay, Outpatient care (including a partial Hospital or intensive Outpatient program) will be paid for as any other Outpatient service.	**80%[1,3]**	**70%[2,3]**

Additional Information
Precertification may be required.
This Schedule of Medical Benefits is intended to provide a summary of benefits. Not all benefit descriptions and exclusions are included in this summary.

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 service, which often is less than the Providers actually charge. The Plan will not pay that portion of Non-Network Provider fees that exceeds Usual, Customary and Reasonable (UCR). You may be responsible for paying that amount.

[1]A Calendar Year Deductible of $350 per Covered Person/$700 per Family is applied first before any Covered Services are paid to Network Providers, and designated Covered Services to Non-Network Providers. Deductible, medical and prescription Copayments and Coinsurance are subject to an Out-of-Pocket Maximum of $1,350 per Covered Person/$2,700 per Family. Once You have met this maximum, the Plan begins to pay medical Covered Services at 100%, except for penalties which are not included in the 100% reimbursement provision.

[2]A Calendar Year Deductible of $350 per Covered Person / $700 per Family is applied first before Covered Services are paid to Non-Network Providers. Payments to Non-Network Provider for Covered Services are based on Usual, Customary and Reasonable criteria (UCR). Deductible, and Coinsurance are subject to an Out-of-Pocket Maximum of $2,350 per Covered Person / $4,700 per Family. Once You have met this maximum, the Plan begins to pay medical Covered Services at 100% UCR, except for penalties which are not included in the 100% reimbursement provision.

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

[4]Deductible does not apply to this benefit. Coinsurance and Copayments are subject to an Out-of-Pocket Maximum of $1,350 per Person/$2,700 per Family. Once You have met this maximum, the Plan begins to pay Medical Covered Services at 100%.

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

[6]Payments to Non-Network Providers for Covered Services are based on Usual, Customary, and Reasonable criteria (UCR). Charges for Non-Network Provider Covered Services that exceed the UCR may be Your responsibility.

[7]There is a combined Medical/Prescription Out-of-Pocket Maximum of $1,350 per Covered Person / $2,700 per Family. Once You have satisfied the combined Medical/Prescription Out-of-Pocket Maximum there is an additional Prescription Out-of-Pocket Maximum of $5,000 per Covered Person / $10,000 per Family. Once You have satisfied the additional $5,000 per Covered Person / $10,000 per Family, prescription Covered Services are payable at 100% for the remainder of the Calendar Year.

SCHEDULE OF MEDICAL BENEFITS - FOP

MEDICAL BENEFITS	NETWORK	NON-NETWORK
Lifetime Maximum	**UNLIMITED**	**UNLIMITED**
Annual Plan Maximum	**None**	**None**
Calendar Year Deductible per Individual	**$350**	**$350**
Calendar Year Deductible per Family	**$700**	**$700**
Maximum Out-of-Pocket per Individual	**$1,350**	**$2,350**
Maximum Out-of-Pocket per Family	**$2,700**	**$4,700**
The Deductible and Out-of-Pocket amounts are Embedded.		
The Plan include Individual and Family last quarter Deductible Carryover.		
The Network and Non-Network Deductibles and Out-of-Pocket amounts are Integrated.		
Amounts spent toward the Calendar Year Deductible count toward the Out-of-Pocket Maximum.		
- Note: Once You have satisfied the combined Medical/Prescription Out-of-Pocket Maximum, there are additional prescription Out-of-Pocket amounts.		
Prescription Out-of-Pocket - Individual	$5,000[7]	
Prescription Out-of-Pocket - Family	$10,000[7]	
- Note: There is a combined Medical/Prescription Out-of-Pocket Maximum of $1,350 per Covered Person / $2,700 per Family. Once You have satisfied the combined Medical/Prescription Out-of-Pocket Maximum, there is an additional prescription Out-of-Pocket Maximum of $5,000 per Covered Person / $10,000 per Family. Once You have satisfied the additional $5,000 per Covered Person / $10,000 per Family, prescription Covered Services are payable at 100% for the remainder of the Calendar Year.		
Inpatient Hospital Care		
Semi-Private Room	**80%[1]**	**70%[2]**
Surgery	**80%[1]**	**70%[2]**
Physician	**80%[1]**	**70%[2]**
Ancillary Services	**80%[1]**	**70%[2]**
Outpatient Services		
Emergency Room (Emergent)	**100%**	**100%[6]**
- Copayment	$200	$200
-- The Copayment is waived if the Covered Person is admitted.		
Urgent Care Facility (Emergent)	**80%[1]**	**80%[1,6]**
Same Day Surgery	**80%[1]**	**70%[2]**
Nursing Services		
Home Health Care Services (Utilization Management approval required)	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Visit limit	100	
Hospice Care (Utilization Management approval required)	**80%[1]**	**80%[2]**
- Bereavement Counseling is a Covered Service.		
Private Duty Nursing - (Utilization Management approval required)	**80%[1]**	**70%[2]**
Skilled Nursing Facility (Utilization Management approval required)	**80%[1]**	**70%[2]**

- Accumulation Type	Calendar Year	
-- Day limit	120	
Other Services		
Allergy Tests	**80%[1]**	**70%[2]**
Allergy Extract	**80%[1]**	**70%[2]**
Allergy Injections	**80%[1]**	**70%[2]**
Ambulance	**80%[1]**	**80%[1,6]**
Diagnostic Testing/Laboratory/X-Ray – Outpatient & Office	**80%[1]**	**70%[2]**
Durable Medical Equipment	**80%[1]**	**70%[2]**
Diabetic Supplies not covered under the Prescription Plan are covered under the Medical Plan.		
Diabetic Supplies	**80%[1]**	**70%[2]**
Orthotics	**80%[1]**	**70%[2]**
Wigs are a Covered Expense. Refer to Durable Medical Equipment benefit.		
- Note: First wig following cancer treatment or alopecia related to a medical condition.		
Infertility Testing – Office & Outpatient	**80%[1]**	**70%[2]**
Infertility Treatment coverage is based on services rendered.		
- Note: Coverage limited to treatment of medical conditions only.		
Maternity Care coverage is based on services rendered.		
Pre-Admission Testing	**80%[1]**	**70%[2]**
Second Surgical Opinion coverage is based on services rendered.		
Care in the Physician's Office		
Primary Care Visit for Illness & Injury	**80%[1]**	**70%[2]**
Specialist Visit for Illness & Injury	**80%[1]**	**70%[2]**
Surgery	**80%[1]**	**70%[2]**
Therapy Services		
Cardiac Rehab Inpatient (Phase I)	**80%[1]**	**70%[2]**
Cardiac Rehab Outpatient (Phase II)	**80%[1]**	**70%[2]**
Chemo and Radiation Therapy – Outpatient & Office	**80%[1]**	**70%[2]**
Manipulation Therapy	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Manipulation Therapy limit	30	
Occupational Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Physical Therapy (Illness/Injury Related) - Inpatient	**80%[1]**	**70%[2]**
Physical Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Rehabilitative Therapy - Inpatient	**80%[1]**	**70%[2]**

Respiratory Therapy – Outpatient & Office	**80%[1]**	**70%[2]**
Speech Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Preventive Care		
Well Baby/Child Care	**100%**	**70%[2]**
Immunizations are included in Well Baby/Child Care.		
- Age limitation (through age)	20	
-- Note: Services for Well Baby/Child Care include, but are not limited to, the Physician's office visit charge and related tests, lab work and immunizations. These Covered Network Services will be paid at 100% unless the Well Baby/Child Care is not defined as a Preventive Health Service.		
Routine Hearing Exam	**100%**	**70%[2]**
- Accumulation Type:		See Note
-- Dollars Maximum	$3,000	
--- Note: Audiology exam, fitting and hearing aids are covered up to a maximum of $3,000, per every four (4) years.		
Hearing Aid	**100%**	**70%[2]**
- Accumulation Type		See Note
-- Dollars Maximum	$3,000	
--- Note: Audiology exam, fitting and hearing aids are covered up to a maximum of $3,000, per every four (4) years.		
Routine Physical Exam	**100%**	**70%[2]**
- Other Services (i.e. preventive screenings)	100%	70%[2]
-- Accumulation Type	Calendar Year	
--- Visits	1	
---- Note: Covered Services for a routine physical include, but are not limited to, the Physician's office visit charge and related tests, X-rays, routine cancer screenings, routine mammograms, routine gynecological exam, routine pap test/smear, age and gender appropriate screening, routine prostate screening, lab work and immunizations. These Network services will be paid at 100% unless the routine physical is not defined as a Preventive Health Service.		
Routine Prostate/PSA Screening	**100%**	**70%[2]**
Routine Gynecological Exam	**100%**	**70%[2]**
Routine Pap Test/Smear	**100%**	**70%[2]**
Routine Immunizations	**100%**	**70%[2]**
Routine Mammograms	**100%**	**70%[2]**
Routine Colonoscopy	**100%**	**70%[2]**
Mental Health and /or Substance Abuse		
Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): **Inpatient care will be paid the same as any other Inpatient stay.** **Please refer to Inpatient Hospital for benefit level.**		
In lieu of an Inpatient stay, Outpatient care (including a partial Hospital or intensive Outpatient program) will be paid for as any other Outpatient service.	**80%[1,3]**	**70%[2,3]**

Additional Information

Precertification may be required.

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

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 service, which often is less than the Providers actually charge. The Plan will not pay that portion of Non-Network Provider fees that exceeds Usual, Customary and Reasonable (UCR). You may be responsible for paying that amount.

[1] Calendar Year Deductible of $350 per Covered Person/$700 per Family is applied first before any Covered Services are paid to Network Providers, and designated Covered Services to Non-Network Providers. Deductible, medical and prescription Copayments and Coinsurance are subject to an Out-of-Pocket Maximum of $1,350 per Covered Person/$2,700 per Family. Once You have met this maximum, the Plan begins to pay medical Covered Services at 100%, except for penalties which are not included in the 100% reimbursement provision.

[2]A Calendar Year Deductible of $350 per Covered Person / $700 per Family is applied first before Covered Services are paid to Non-Network Providers. Payments to Non-Network Provider for Covered Services are based on Usual, Customary and Reasonable criteria (UCR). Deductible, and Coinsurance are subject to an Out-of-Pocket Maximum of $2,350 per Covered Person / $4,700 per Family. Once You have met this maximum, the Plan begins to pay medical Covered Services at 100% UCR, except for penalties which are not included in the 100% reimbursement provision.

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

[4]Deductible does not apply to this benefit. Coinsurance and Copayments are subject to an Out-of-Pocket Maximum of $1,350 per Person/$2,700 per Family. Once You have met this maximum, the Plan begins to pay Medical Covered Services at 100%.

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

[6]Payments to Non-Network Providers for Covered Services are based on Usual, Customary, and Reasonable criteria (UCR). Charges for Non-Network Provider Covered Services that exceed the UCR may be Your responsibility.

[7]There is a combined Medical/Prescription Out-of-Pocket Maximum of $1,350 per Covered Person / $2,700 per Family. Once You have satisfied the combined Medical/Prescription Out-of-Pocket Maximum, there is an additional prescription Out-of-Pocket Maximum of $5,000 per Covered Person / $10,000 per Family. Once You have satisfied the additional $5,000 per Covered Person / $10,000 per Family, prescription Covered Services are payable at 100% for the remainder of the Calendar Year.

SCHEDULE OF MEDICAL BENEFITS – NON-BARGAINING

MEDICAL BENEFITS	NETWORK	NON-NETWORK
Lifetime Maximum	**UNLIMITED**	**UNLIMITED**
Annual Plan Maximum	**None**	**None**
Calendar Year Deductible per Individual	**$350**	**$350**
Calendar Year Deductible per Family	**$700**	**$700**
Maximum Out-of-Pocket per Individual	**$1,350**	**$2,350**
Maximum Out-of-Pocket per Family	**$2,700**	**$4,700**
The Deductible and Out-of-Pocket amounts are Embedded.		
The Plan include Individual and Family last quarter Deductible Carryover.		
The Network and Non-Network Deductibles and Out-of-Pocket amounts are Integrated.		
Amounts spent toward the Calendar Year Deductible count toward the Out-of-Pocket Maximum.		
- Note: Once You have satisfied the combined medical/prescription Out-of-Pocket Maximum, there are additional prescription Out-of-Pocket amounts.		
Prescription Out-of-Pocket - Individual	$5,000[7]	
Prescription Out-of-Pocket - Family	$10,000[7]	
- Note: There is a combined medical/prescription Out-of-Pocket Maximum of $1,350 per Covered Person / $2,700 per Family. Once You have satisfied the combined medical/prescription Out-of-Pocket Maximum there is an additional prescription Out-of-Pocket Maximum of $5,000 per Covered Person / $10,000 per Family. Once You have satisfied the additional $5,000 per Covered Person / $10,000 per Family, prescription Covered Services are payable at 100% for the remainder of the Calendar Year.		
Inpatient Hospital Care		
Semi-Private Room	**80%[1]**	**70%[2]**
Surgery	**80%[1]**	**70%[2]**
Physician	**80%[1]**	**70%[2]**
Ancillary Services	**80%[1]**	**70%[2]**
Outpatient Services		
Emergency Room (Emergent)	**100%**	**100%[6]**
- Copayment	$200	$200
-- The Copayment is waived if the Covered Person is admitted.		
Urgent Care Facility (Emergent)	**80%[1]**	**80%[1,6]**
Same Day Surgery	**80%[1]**	**70%[2]**
Nursing Services		
Home Health Care Services (Utilization Management approval required)	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Visit limit	100	

Hospice Care (Utilization Management approval required)	**80%[1]**	**80%[2]**
- Bereavement Counseling is a Covered Service.		
Private Duty Nursing - (Utilization Management approval required)	**80%[1]**	**70%[2]**
Skilled Nursing Facility (Utilization Management approval required)	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Day limit	120	
Other Services		
Allergy Tests	**80%[1]**	**70%[2]**
Allergy Extract	**80%[1]**	**70%[2]**
Allergy Injections	**80%[1]**	**70%[2]**
Ambulance	**80%[1]**	**80%[1,6]**
Diagnostic Testing/Laboratory/X-Ray – Outpatient & Office	**80%[1]**	**70%[2]**
Durable Medical Equipment	**80%[1]**	**70%[2]**
Diabetic Supplies not covered under the Prescription Plan are covered under the Medical Plan.		
Diabetic Supplies	**80%[1]**	**70%[2]**
Orthotics	**80%[1]**	**70%[2]**
Wigs are a Covered Expense. Refer to Durable Medical Equipment benefit.		
- Note: First wig following cancer treatment or alopecia related to a medical condition.		
Infertility Testing – Office & Outpatient	**80%[1]**	**70%[2]**
Infertility Treatment coverage is based on services rendered.		
- Note: Coverage limited to treatment of medical conditions only.		
Maternity Care coverage is based on services rendered.		
Pre-Admission Testing	**80%[1]**	**70%[2]**
Second Surgical Opinion coverage is based on services rendered.		
Care in the Physician's Office		
Primary Care Visit for Illness & Injury	**80%[1]**	**70%[2]**
Specialist Visit for Illness & Injury	**80%[1]**	**70%[2]**
Surgery	**80%[1]**	**70%[2]**
Therapy Services		
Cardiac Rehab Inpatient (Phase I)	**80%[1]**	**70%[2]**
Cardiac Rehab Outpatient (Phase II)	**80%[1]**	**70%[2]**
Chemo and Radiation Therapy – Outpatient & Office	**80%[1]**	**70%[2]**
Manipulation Therapy	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Manipulation Therapy limit	30	
Occupational Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Physical Therapy (Illness/Injury Related) - Inpatient	**80%[1]**	**70%[2]**
Physical Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**

Rehabilitative Therapy - Inpatient	**80%[1]**	**70%[2]**
Respiratory Therapy – Outpatient & Office	**80%[1]**	**70%[2]**
Speech Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Preventive Care		
Well Baby/Child Care	**100%**	**70%[2]**
Immunizations are included in Well Baby/Child Care.		
- Age limitation (through age)	20	
-- Note: Services for Well Baby/Child Care include, but are not limited to, the Physician's office visit charge and related tests, lab work and immunizations. These Covered Network services will be paid at 100% unless the Well Baby/Child Care is not defined as a Preventive Health Service.		
Routine Hearing Exam	**100%**	**70%[2]**
- Accumulation Type:		See Note
-- Dollars Maximum	$3,000	
--- Note: Audiology exam, fitting and hearing aids are covered up to a maximum of $3,000, per every four (4) years.		
Hearing Aid	**100%**	**70%[2]**
- Accumulation Type		See Note
-- Dollars Maximum	$3.000	
--- Note: Audiology exam, fitting and hearing aids are covered up to a maximum of $3,000, per every four (4) years.		
Routine Physical Exam	**100%**	**70%[2]**
- Other Services (i.e. preventive screenings)	100%	70%[2]
-- Accumulation Type	Calendar Year	
--- Visits	1	
---- Note: Covered Services for a routine physical include, but are not limited to, the Physician's office visit charge and related tests, X-rays, routine cancer screenings, routine mammograms, routine gynecological exam, routine pap test/smear, age and gender appropriate screening, routine prostate screening, lab work and immunizations. These Network services will be paid at 100% unless the routine physical is not defined as a Preventive Health Service.		
Routine Prostate/PSA Screening	**100%**	**70%[2]**
Routine Gynecological Exam	**100%**	**70%[2]**
Routine Pap Test/Smear	**100%**	**70%[2]**
Routine Immunizations	**100%**	**70%[2]**
Routine Mammograms	**100%**	**70%[2]**
Routine Colonoscopy	**100%**	**70%[2]**
Mental Health and /or Substance Abuse		
Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA):		
Inpatient care will be paid the same as any other Inpatient stay.		
Please refer to Inpatient Hospital for benefit level.		
In lieu of an Inpatient stay, Outpatient care (including a partial Hospital or intensive Outpatient program) will be paid for as any other Outpatient service.	**80%[1,3]**	**70%[2,3]**

Additional Information

Precertification may be required.

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

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 service, which often is less than the Providers actually charge. The Plan will not pay that portion of Non-Network Provider fees that exceeds Usual, Customary and Reasonable (UCR). You may be responsible for paying that amount.

[1]A Calendar Year Deductible of $350 per Covered Person/$700 per Family is applied first before any Covered Services are paid to Network Providers, and designated Covered Services to Non-Network Providers. Deductible, medical and prescription Copayments and Coinsurance are subject to an Out-of-Pocket Maximum of $1,350 per Covered Person/$2,700 per Family. Once You have met this maximum, the Plan begins to pay medical Covered Services at 100%, except for penalties which are not included in the 100% reimbursement provision.

[2]A Calendar Year Deductible of $350 per Covered Person / $700 per Family is applied first before Covered Services are paid to Non-Network Providers. Payments to Non-Network Provider for Covered Services are based on Usual, Customary and Reasonable criteria (UCR). Deductible and Coinsurance are subject to an Out-of-Pocket Maximum of $2,350 per Covered Person / $4,700 per Family. Once You have met this maximum, the Plan begins to pay medical Covered Services at 100% UCR, except for penalties which are not included in the 100% reimbursement provision.

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

[4]Deductible does not apply to this benefit. Coinsurance and Copayments are subject to an Out-Of-Pocket maximum of $1,350 per person/$2,700 per family. Once You have met this maximum, the Plan begins to pay Medical Covered Services at 100%.

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

[6]Payments to Non-Network Providers for Covered Services are based on Usual, Customary, and Reasonable criteria (UCR). Charges for Non-Network Provider Covered Services that exceed the UCR may be Your responsibility.

[7]There is a combined Medical/Prescription Out-of-Pocket Maximum of $1,350 per Covered Person / $2,700 per Family. Once You have satisfied the combined Medical/Prescription Out-of-Pocket Maximum there is an additional Prescription Out-of-Pocket Maximum of $5,000 per Covered Person / $10,000 per Family. Once You have satisfied the additional $5,000 per Covered Person / $10,000 per Family, prescription Covered Services are payable at 100% for the remainder of the Calendar Year.

SCHEDULE OF MEDICAL BENEFITS – POLICE CPPA BARGAINING

MEDICAL BENEFITS	NETWORK	NON-NETWORK
Lifetime Maximum	**UNLIMITED**	**UNLIMITED**
Annual Plan Maximum	**None**	**None**
Calendar Year Deductible per Individual	**$350**	**$350**
Calendar Year Deductible per Family	**$700**	**$700**
Maximum Out-of-Pocket per Individual	**$1,350**	**$2,350**
Maximum Out-of-Pocket per Family	**$2,700**	**$4,700**
The Deductible and Out-of-Pocket amounts are Embedded.		
The Plan includes Individual and Family last quarter Deductible Carryover.		
The Network and Non-Network Deductibles and Out-of-Pocket amounts are Integrated.		
Amounts spent toward the Calendar Year Deductible count toward the Out-of-Pocket Maximum.		
- Note: Once You have satisfied the combined medical/prescription Out-of-Pocket Maximum, there are additional prescription Out-of-Pocket amounts.		
Prescription Out-of-Pocket - Individual	$5,000[7]	
Prescription Out-of-Pocket - Family	$10,000[7]	
- Note: There is a combined medical/prescription Out-of-Pocket Maximum of $1,350 per Covered Person / $2,700 per Family. Once You have satisfied the combined medical/prescription Out-of-Pocket Maximum there is an additional prescription Out-of-Pocket Maximum of $5,000 per Covered Person / $10,000 per Family. Once You have satisfied the additional $5,000 per Covered Person / $10,000 per Family, prescription Covered Services are payable at 100% for the remainder of the Calendar Year.		
Inpatient Hospital Care		
Semi-Private Room	**80%[1]**	**70%[2]**
Surgery	**80%[1]**	**70%[2]**
Physician	**80%[1]**	**70%[2]**
Ancillary Services	**80%[1]**	**70%[2]**
Outpatient Services		
Emergency Room (Emergent)	**100%**	**100%[6]**
- Copayment	$200	$200
-- The Copayment is waived if the Covered Person is admitted.		
Urgent Care Facility (Emergent)	**80%[1]**	**80%[1,6]**
Same Day Surgery	**80%[1]**	**70%[2]**
Nursing Services		
Home Health Care Services (Utilization Management approval required)	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Visit limit	100	

Hospice Care (Utilization Management approval required)	**80%[1]**	**80%[2]**
- Bereavement Counseling is a Covered Service.		
Private Duty Nursing - (Utilization Management approval required)	**80%[1]**	**70%[2]**
Skilled Nursing Facility (Utilization Management approval required)	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Day limit	120	
Other Services		
Allergy Tests	**80%[1]**	**70%[2]**
Allergy Extract	**80%[1]**	**70%[2]**
Allergy Injections	**80%[1]**	**70%[2]**
Ambulance	**80%[1]**	**80%[1,6]**
Diagnostic Testing/Laboratory/X-Ray – Outpatient & Office	**80%[1]**	**70%[2]**
Durable Medical Equipment	**80%[1]**	**70%[2]**
Diabetic Supplies not covered under the Prescription Plan are covered under the Medical Plan.		
Diabetic Supplies	**80%[1]**	**70%[2]**
Orthotics	**80%[1]**	**70%[2]**
Wigs are a Covered Expense. Refer to Durable Medical Equipment benefit.		
- Note: First wig following cancer treatment or alopecia related to a medical condition.		
Infertility Testing – Office & Outpatient	**80%[1]**	**70%[2]**
Infertility Treatment		
- Note: Coverage limited to treatment of medical conditions only.		
Maternity Care coverage is based on services rendered.		
Pre-Admission Testing	**80%[1]**	**70%[2]**
Second Surgical Opinion coverage is based on services rendered.		
Care in the Physician's Office		
Primary Care Visit for Illness & Injury	**80%[1]**	**70%[2]**
Specialist Visit for Illness & Injury	**80%[1]**	**70%[2]**
Surgery	**80%[1]**	**70%[2]**
Therapy Services		
Cardiac Rehab Inpatient (Phase I)	**80%[1]**	**70%[2]**
Cardiac Rehab Outpatient (Phase II)	**80%[1]**	**70%[2]**
Chemo and Radiation Therapy – Outpatient & Office	**80%[1]**	**70%[2]**
Manipulation Therapy	**80%[1]**	**70%[2]**
- Accumulation Type	Calendar Year	
-- Manipulation Therapy limit	30	

Occupational Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Physical Therapy (Illness/Injury Related) - Inpatient	**80%[1]**	**70%[2]**
Physical Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Rehabilitative Therapy - Inpatient	**80%[1]**	**70%[2]**
Respiratory Therapy – Outpatient & Office	**80%[1]**	**70%[2]**
Speech Therapy (Illness/Injury Related) – Outpatient & Office	**80%[1]**	**70%[2]**
Preventive Care		
Well Baby/Child Care	**100%**	**70%[2]**
Immunizations are included in Well Baby/Child Care.		
- Age limitation (through age)	20	
-- Note: Services for Well Baby/Child Care include, but are not limited to, the Physician's office visit charge and related tests, lab work and immunizations. These Covered Network services will be paid at 100% unless the Well Baby/Child Care is not defined as a Preventive Health Service.		
Routine Hearing Exam	**100%**	**70%[2]**
- Accumulation Type:		See Note
-- Dollars Maximum	$3,000	
--- Note: Audiology exam, fitting and hearing aids are covered up to a maximum of $3,000, per every four (4) years.		
Hearing Aid	**100%**	**70%[2]**
- Accumulation Type	See Note	
-- Dollars Maximum	$3,000	
--- Note: Audiology exam, fitting and hearing aids are covered up to a maximum of $3,000, per every four (4) years.		
Routine Physical Exam	**100%**	**70%[2]**
- Other Services (i.e. preventive screenings)	100%	70%[2]
-- Accumulation Type	Calendar Year	
--- Visits	1	
---- Note: Covered Services for a routine physical include, but are not limited to, the Physician's office visit charge and related tests, X-rays, routine cancer screenings, routine mammograms, routine gynecological exam, routine pap tests/smear, age and gender appropriate screening, routine prostate screening, lab work and immunizations. These Network services will be paid at 100% unless the routine physical is not defined as a Preventive Health Service.		
Routine Prostate/PSA Screening	**100%**	**70%[2]**
Routine Gynecological Exam	**100%**	**70%[2]**
Routine Pap Test/Smear	**100%**	**70%[2]**
Routine Immunizations	**100%**	**70%[2]**
Routine Mammograms	**100%**	**70%[2]**
Routine Colonoscopy	**100%**	**70%[2]**
Mental Health and /or Substance Abuse		
Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA):		

Inpatient care will be paid the same as any other Inpatient stay.		
Please refer to Inpatient Hospital for benefit level.		
In lieu of an Inpatient stay, Outpatient care (including a partial Hospital or intensive Outpatient program) will be paid for as any other Outpatient service.	**80%[1,3]**	**70%[2,3]**

Additional Information

Precertification may be required.

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

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[1]A Calendar Year Deductible of $350 per Covered Person/$700 per Family is applied first before any Covered Services are paid to Network Providers, and designated Covered Services to Non-Network Providers. Deductible, medical and prescription Copayments and Coinsurance are subject to an Out-of-Pocket Maximum of $1,350 per Covered Person/$2,700 per Family. Once You have met this maximum, the Plan begins to pay medical Covered Services at 100%, except for penalties which are not included in the 100% reimbursement provision.

[2]A Calendar Year Deductible of $350 per Covered Person / $700 per Family is applied first before Covered Services are paid to Non-Network Providers. Payments to Non-Network Provider for Covered Services are based on Usual, Customary and Reasonable criteria (UCR). Deductible, and Coinsurance are subject to an Out-of-Pocket Maximum of $2,350 per Covered Person / $4,700 per Family. Once You have met this maximum, the Plan begins to pay medical Covered Services at 100% UCR, except for penalties which are not included in the 100% reimbursement provision.

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

[4]Deductible does not apply to this benefit. Coinsurance and copayments are subject to an Out-Of-Pocket maximum of $1,350 per person/$2,700 per family. Once You have met this maximum, the Plan begins to pay Medical Covered Services at 100%.

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

[6]Payments to Non-Network Providers for Covered Services are based on Usual, Customary, and Reasonable criteria (UCR). Charges for Non-Network Provider Covered Services that exceed the UCR may be Your responsibility.

[7]There is a combined medical/prescription Out-of-Pocket Maximum of $1,350 per Covered Person / $2,700 per Family. Once You have satisfied the combined medical/prescription Out-of-Pocket Maximum there is an additional prescription Out-of-Pocket Maximum of $5,000 per Covered Person / $10,000 per Family. Once You have satisfied the additional $5,000 per Covered Person / $10,000 per Family, prescription Covered Services are payable at 100% for the remainder of the Calendar Year.

USUAL, CUSTOMARY AND REASONABLE ("UCR")

Your Plan is committed to offering health care benefits for Eligible Expenses at reasonable rates. Your Benefits are greatest when You receive Covered Services from a Network Provider.

Some Plans require Covered Persons to stay within the Network. Your Plan permits You to go outside the Network. If You go outside the Network, however, You will be responsible for paying what Your Plan does not pay, since Your Plan has no control over what Non-Network Providers charge.

The amount Your Plan pays to a Non-Network Provider often is less than the Non-Network Provider charges and may be less than the amount Your Plan pays to a Network Provider for the same service. You are responsible for paying the balance between the total charges and the amount Your Plan pays to Non-Network Providers. Consequently, there may be a financial incentive for You to use Network Providers.

Before choosing a Non-Network Provider, You are encouraged to find out what the Non-Network Provider charges for a particular service and what Your Plan will pay for that service. It is also suggested that You compare what Your Plan will pay for the Non-Network Provider's service to the amount Your Plan would pay if the service were furnished by a Network Provider. You may contact the Customer Service Center for assistance.

For example: If a Non-Network Provider charges You a fee of $125 for a procedure, and the UCR amount Your Plan has determined for this procedure is $100, then Your Plan will pay up to the UCR amount ($100), minus Your Cost Share. You would be responsible for paying the amount that exceeds UCR, which is $25 plus any Cost Share.

You are not responsible for paying any amount that exceeds the negotiated rate when You go to a Network Provider.

EXCEPTIONS TO NON-NETWORK BENEFITS:

The benefits provided and percentage paid under the Plan will depend on whether services are received from a Network Provider or a Non-Network Provider. A list of the Network Providers can be obtained from the Third Party Administrator. You may also choose to visit the Third Party Administrator's website at www.aultcare.com. Services include a Provider directory, frequently asked questions (FAQs) and online forms.

In order for charges to be eligible for Network Benefits, all services must be provided by a Network Provider; however, Network Benefits will be payable if a Non-Network Provider or facility must be utilized by a Covered Person due to an Emergency Medical Condition. UCR may or may not apply.

Certain Medically Necessary Services by an AultCare approved Centers of Excellence Provider will be covered at the same level as a Network Provider if such services are not offered by Network Providers. Precertification and prior Plan approval is required for these services to be covered by an AultCare approved Centers of Excellence Provider at Network level. UCR may or may not apply.

PRECERTIFICATION

The Medical Benefits under this Plan have been designed to encourage a Covered Person to seek quality health care using our Network Providers. Medical Benefits will be reimbursed at the levels shown in the Schedule of Benefits if the Covered Person insures all provisions and requirements are met, such as applicable Precertifications for certain services such as Inpatient Hospital, Home Health Care Services, Skilled Nursing, Genetic Testing and Hospice services. If the Covered Person is Hospital confined on an Inpatient basis prior to having that Hospitalization Precertified, benefits may be reimbursed at a lower level. If Your medical professional is a Network Provider, the Precertification process will be handled for You by Your Provider when required. You are responsible for alerting the Provider to follow the Precertification information on the back of Your ID card. However, if Your medical professional is not a Network Provider, Precertification is required and You are responsible for seeing that Utilization Management procedures are followed.

Precertification (also called "Prior Authorization") is an evaluation of Your medical case by Your Provider and AultCare medical professionals to determine the appropriateness of the services requested. It means You or Your Network Provider must notify Utilization Management before You may receive certain services, such as an elective Hospital stay, Transplants, and other Outpatient and Provider services. Certain referrals by Providers may require Precertification. Precertification is needed to help determine if other appropriate medical care possibilities have been explored and are within acceptable time elements. Precertification is a separate process from benefit determination. The fact that a Provider referred You for certain services, or that Prior Authorization was given, does not guarantee that Your Claim will be paid at the Network Provider level, or at the highest benefit level. Precertification is not required for the treatment of Emergency Medical Conditions.

PRECERTIFICATION IS REQUIRED UNDER YOUR PLAN FOR ALL OF THE FOLLOWING:

1. You are admitted to the Hospital or any facility.
2. You need to be seen by a Non-Network Provider and You are requesting payment at the Network Provider level.
3. You need Durable Medical Equipment with a purchase price of $1,500 or greater.
4. For admission to a Network or Non-Network Inpatient or Outpatient Residential Treatment Facility.
5. You need certain Diagnostic Testing that may require Precertification.
6. You need Home Health Care Services, Skilled Nursing, and Hospice Care services.
7. Your Physician ordered Genetic Testing.
8. You are prescribed an Opioid analgesic for treatment of chronic pain except when You are in Hospice Care, being treated for a Terminal Illness, or have cancer or a history of cancer.
9. Your Physician orders, or You are receiving, care that requires a prior assessment to determine if the service or treatment meets clinical requirements for Medical Necessity, appropriateness, level of care, or effectiveness.

This list of services that must be Precertified may be revised by the Plan from time to time. For a complete list of services requiring Precertification, please contact 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.

CALL THE CUSTOMER SERVICE CENTER TO CONFIRM THE REQUIREMENTS UNDER YOUR PLAN.

Precertification requires that You or someone from Your Physician's office call the phone number shown on the back of Your I.D. card for any Service or item requiring Precertification and speak with a Nurse in the Utilization Management Department and provide the following information: the patient's name, address, date of birth and relationship to the Employee; the Employee's identification number, name of the Employer and the group number (information found on Your I.D. card); the Physician's name, address, telephone number and the name of the facility where the service will be performed; and the dates of the Hospitalization, service or supply and a brief description of the medical treatment plan

(what is going to be done and why). If You ask Your Physician's office to make the Precertification phone call and the call isn't made timely (information found on Your I.D. card), then You may be penalized for failure to Precertify. You must obtain approval from the Utilization Management Department in order for a service or item to be Precertified.

NON-EMERGENT CARE OR ELECTIVE INPATIENT HOSPITALIZATIONS: You or Your Non-Network Physician must call the number on the back of Your I.D. card as soon as possible prior to the proposed Hospital admission.

OPIOID DEPENDENCE TREATMENT: Requests for opioid dependence treatment at any level of care throughout the continuum will be handled as an expedited review.

RESIDENTIAL TREATMENT FACILITY CARE: If You are referred to a Residential Treatment Facility for a Mental Health and/or Substance Abuse condition, Your stay must be Precertified and receive Plan approval prior to the services being rendered. Precertification is required under Your Plan of benefits for Network and Non-Network Inpatient/Outpatient Residential Treatment Facility admissions.

PLAN APPROVAL: In addition, there are some surgical procedures, diagnostic tests, and services that require Plan approval prior to the services being rendered. If You need certain Medically Necessary services offered through an approved Centers of Excellence Provider, when such services are not available in Network, Plan approval is required. This approval process may require obtaining additional information from You or Your Physician.

PREGNANCY: Precertification does not apply to any normal vaginal delivery for which You are Hospitalized for forty-eight (48) hours or less or to any caesarean section for which You are Hospitalized for ninety-six (96) hours or less. However, if You require additional time in the Hospital You or Your Physician must call the number shown on the back of Your I.D. card within forty-eight (48) hours or within two working days after the forty-eight (48) hours for a normal vaginal delivery or the ninety-six (96) hours for a caesarean section.

REFERRAL PROCEDURE: On occasion, it may be necessary for Your Network Provider to refer You to a Physician outside the Network. In order for You to receive the greatest benefit possible from Your Plan, the following procedure must be followed:

Your Network Provider must contact the pre-admission coordinator at the Utilization Management Department to explain the circumstances of the referral. This can be done by telephone or by completing a referral form available to the Physician.

The completed referral request will be reviewed by the Utilization Management Department's Medical Director. You and Your Physician will be contacted directly as to whether the referral has been approved. If You do not receive written confirmation of Your referral, please contact the Utilization Management Department at the number shown on the back of Your I.D. card prior to Your appointment at the Non-Network Provider. When a referral is approved at the Network level, benefits will be payable as outlined for other Network Providers, and may be subject to Usual, Customary and Reasonable (UCR) limitation.

When a referral is not approved, approved at the Non-Network level, or the above procedure is not followed, benefits are payable as outlined for other Non-Network Providers.

PRECERTIFICATION OF NON-URGENT CARE CLAIMS (A PRE-SERVICE CLAIM): If a proposed Hospitalization or other Covered Service requires Precertification under the Plan, and Your Provider submits a Precertification request through our electronic portal, then we will respond to Your Provider within ten (10)-days of receipt of the request. If the Precertification request is submitted in different manner, we will respond within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15)-days. The Precertification determination will be sent in one of the four manners: via mail, via fax, via email, or electronically.

If You or Your Provider failed to provide needed information when Precertifying, a notice will be provided within five (5)-days of the date the Precertification request is received by the Plan; the notice may be oral or electronic, unless You or Your authorized representative request notification in another manner. You or Your Provider will then have forty-five (45)-days to provide the missing information. If the missing information is provided to the Utilization Management Department within the forty-five (45)-day period and all information needed to make the benefit determination has been received, then a notice of the determination will be provided to You or Your Provider. The notice will be sent in one of four manners: via mail, via fax, via email, or electronically.

If there is an Adverse Benefit Determination of the Precertification Non-Urgent Care Claim (if the services or treatment being Precertified will be denied in whole or in part), You will have 180 days in which to appeal the determination. The Plan will have ten (10)-days from the date the appeal is received to make a determination on the appeal. Refer to the section entitled "Claims Information" for additional information on the appeal process, including internal and external appeals.

PRECERTIFICATION OF URGENT CARE CLAIMS (A PRE-SERVICE CLAIM): If a proposed Hospitalization or other Covered Service requires Precertification under the Plan and the Precertification claim involves medical care or services for a condition where application of the timeframe for making routine or non-life threatening care determinations (a) could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state or (b) would, in the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, subject the patient to adverse health consequences without the care or treatment being provided, the request will be considered an Urgent Care Precertification claim. To determine if a Precertification claim involves Urgent Care, the Plan will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if the Covered Person's Provider determines that the Precertification claim is involves Urgent Care, the claim must be treated as an Urgent Care claim.

If Your Provider submits an Urgent Care Precertification request through our electronic portal, then we will respond to Your Provider electronically within twenty-four (24) hours of receipt of the request. If the Urgent Care Precertification request is submitted in different manner, we will respond orally within a reasonable period of time appropriate to the medical circumstances, but not later than forty-eight (48) hours of receipt of the request, with written notice not later than three (3)-days after the oral determination. The written Precertification determination will be sent in one of the four manners: via mail, via fax, via email, or electronically.

If You or Your Provider failed to provide needed information when Precertifying, a notice will be provided within twenty-four (24) hours of receipt of the original request. You or Your Physician will then have a minimum of forty-eight (48) hours to provide the missing information. Once the missing information is provided to the Utilization Management Department, a benefit determination will be made no later than twenty-four (24) for electronic requests or forty-eight (48) hours for other requests after the missing information is received.

If there is an Adverse Benefit Determination of the Urgent Care Precertification Claim (if the services or treatment being Precertified will be denied in whole or in part), You will have 180 days in which to appeal the determination. The Plan will have a reasonable period of time taking into account medical needs, but not later than forty-eight (48) hours from the date the Urgent Care Precertification appeal is received to make a determination on the appeal. Refer to the section entitled "Claims Information" for additional information on the appeal process, including internal and external appeals.

UTILIZATION REVIEW: When a Covered Person is scheduled for admission to a Hospital or Residential Treatment Facility on an Inpatient or Outpatient basis, notification must be given to the Plan as shown above.

Failure to Precertify the admission may result in reduced payment in accordance with the precertification provisions. During each Hospital or Residential Treatment Facility stay, an assessment of the Individual's ongoing treatment will be confirmed by the Utilization Management Department. They will also coordinate, as needed, for a prompt discharge from the admitting facility consistent with sound, efficient, medical practice, in consultation with the attending Physician, the admitting facility, and the local community resources.

CONCURRENT REVIEW: The Utilization Management Department will contact the treating Physician near the end of the Hospital or Inpatient/Outpatient Residential Treatment Facility confinement period to verify the Covered Person will be discharged from the Hospital or Residential Treatment Facility within the time period initially authorized by the Utilization Management Department. If the admitting Physician determines that the Covered Person needs to be confined for a longer period than the amount of time which was initially authorized by the Utilization Management Department, then the additional period of confinement must be certified by the Utilization Management Department.

If the admitting Physician determines that the concurrent review involves an Urgent Care claim and the extension of the Hospitalization or further treatment must be decided as soon as possible, then oral notification of the benefit determination will be provided to the claimant within twenty-four (24) hours after receipt of the concurrent care information requesting an extension, but only if the Physician contacts the Utilization Management Department within twenty-four (24) hours of the expiration of the time period that was initially authorized. If the Physician's request for concurrent review of an Urgent Care claim is not made within at least twenty-four (24) hours of the expiration of the prescribed period for time or number of treatments, then a benefit determination will be made as soon as possible, but not later than seventy-two (72) hours after receipt of the request. The notification will be provided electronically or orally; and, if orally, a written notice will be furnished

not later than three (3) days after the oral determination. The written notice will be sent in one of three manners: via mail, via fax or via email. Refer to the section entitled “Claims Information”, to the paragraph entitled “Time Limit for Filing Claims Appeals” for additional information on the appeal process.

SECOND SURGICAL OPINION: When a Covered Person has been advised to have Surgery at a Hospital on an Inpatient basis, eligible charges in connection with the second (or third) opinion will be paid according to the Schedule of Benefits. If a second opinion does not confirm the need for Surgery, a third consultation for a third opinion may be necessary. Surgical opinions must be obtained from a board-certified surgeon and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

CASE MANAGEMENT: When a Covered Person's condition (such as a catastrophic Injury or chronic Illness) warrants, the person's attending Physician will be contacted to review all available resources that may be utilized to maximize the person's recovery. Areas that may be reviewed with the attending Physician include rehabilitation resources, public assistance programs, and alternative forms of treatment. Under certain unusual or specialized circumstances, the Plan Administrator may consider covering charges that would not be covered by the Plan, but only if the proposed treatment proves to be approved by the medical community and would be more cost effective than an alternative form of treatment which would otherwise be eligible for benefits under the Plan. Prior to any final determination, however, the length, severity, and prognosis of the person's condition will be taken into consideration; however, the decision on the course of treatment selected ultimately lies with the Covered Person. Case Management provides suggested, not mandatory, treatment care plans.

OUTPATIENT SURGERY: Frequently, it is possible for Surgery to be performed as a Hospital Outpatient, in a Physician's office or in a freestanding surgical center. Outpatient Surgery is normally more convenient and less costly since the expense of Inpatient Hospital care is avoided. Your Plan encourages Outpatient Surgery when it is medically appropriate.

MEDICAL BENEFITS

DEDUCTIBLE, COINSURANCE, AND COPAYMENT

DEDUCTIBLE: The Network Calendar Year Deductible, as shown in the Schedule of Benefits, is the amount of Eligible Expenses which must be incurred by each Covered Person (if applicable) before any benefits are payable for Network Eligible Expenses, unless stated otherwise in the Schedule of Benefits. The Non-Network Calendar Year Deductible, as shown in the Schedule of Benefits, is the amount of Eligible Expenses which must be incurred by each Covered Person (if applicable) before any benefits are payable for Non-Network Eligible Expenses, unless stated otherwise in the Schedule of Benefits.

INTEGRATED DEDUCTIBLE: If a combination of Network and Non-Network Providers are utilized, charges applied to the Network Deductible will be applied towards the satisfaction of the Non-Network Deductible; charges applied to the Non-Network Deductible will be applied towards the satisfaction of the Network Deductible. In no event will the Eligible Expenses applied to the Calendar Year Deductible exceed the Non-Network Calendar Year Deductible shown in the Schedule of Benefits.

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

NON-NETWORK ACCUMULATED DEDUCTIBLE: If more than one Covered Person in a Family incurs expenses during a Calendar Year and the accumulated expenses payable by those Individuals exceed the Non-Network Family Deductible shown in the Schedule of Benefits, the Non-Network Deductible will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

EMBEDDED DEDUCTIBLE: Each member of a Family is looked upon as an Individual in regard to the Deductible. Once a member reaches the Individual Deductible, the Plan's Coinsurance will apply. Any combination of Family members may satisfy the Family Deductible; however, no member may satisfy more than his or her Individual Deductible amount.

Any amounts paid by an Individual for the following will not apply towards the satisfaction of the Calendar Year Deductible shown in the Schedule of Benefits:

1. Any charge which is not eligible under the Plan; or
2. Medical Copayments, or
3. Prescription Drug Copayments.

The Third Party Administrator reserves the right to allocate the Calendar Year 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.

DEDUCTIBLE CARRYOVER: The Plan contains a Deductible carryover feature. This provision states that any Eligible Expenses applied against the Individual and Family Deductible in the last three (3) months of a Calendar Year, will also be applied against the Individual and Family Deductibles for the next Calendar Year. Deductible carryover does not apply to the Out-of-Pocket Maximum.

COPAYMENT: The dollar amount or percentage of costs shown in the Schedule of Benefits that a Covered Person must pay (Cost Share) directly to the Provider for certain Covered Services, usually when You receive the service.

COINSURANCE: 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.)

COST SHARE: The portion of the Eligible Expenses that You are required to pay. This includes Deductibles, Coinsurance, and/or Copayments. This does not include premiums, amounts over UCR or ineligible Expenses.

OUT-OF-POCKET MAXIMUM: The maximum Cost Share You are required to pay for a Covered Person under the Plan. Once the Out-of-Pocket Maximum is met, the Plan will pay the remaining Eligible Expenses under the Plan for Essential Health Benefits for the remainder of the Calendar Year. (Refer to the Schedule of Benefits.) There can be an Out-of-Pocket Maximum on medical expenses and a separate one for prescription drug expenses, but the two together cannot exceed the Maximum Out-of-Pocket Limit.

INTEGRATED OUT-OF-POCKET: If a combination of Network and Non-Network Providers are utilized, charges applied to the Network Out-of-Pocket will be applied towards the satisfaction of the Non-Network Out-of-Pocket; charges applied to the Non-Network Out-of-Pocket will be applied towards the satisfaction of the Network Out-of-Pocket. In no event will the Eligible Expenses applied to the Calendar Year Out-of-Pocket exceed the Non-Network Calendar Year Out-of-Pocket shown in the Schedule of Benefits.

NETWORK ACCUMULATED OUT-OF-POCKET: If more than one Covered Person in a Family incurs expenses during a Calendar Year and the accumulated expenses payable by those Individuals exceed the Network Family Out-of-Pocket shown in the Schedule of Benefits, the Network Out-of-Pocket will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

NON-NETWORK ACCUMULATED OUT-OF-POCKET: If more than one Covered Person in a Family incurs expenses during a Calendar Year and the accumulated expenses payable by those Individuals exceed the Non-Network Family Out-of-Pocket shown in the Schedule of Benefits, the Non-Network Out-of-Pocket will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

EMBEDDED OUT-OF-POCKET: Each member of a Family is looked upon as an Individual in regard to the Out-of-Pocket. Once a member reaches the Individual Out-of-Pocket Maximum, the Plan will begin to pay at 100% of Eligible Expenses for that member. Any combination of Family members may satisfy the Family Out-of-Pocket, at which time the Plan will begin to pay Covered Services at 100% for the entire Family; however, a single member will not be required to satisfy more than his or her Individual Out-of-Pocket amount.

Any amounts paid by an Individual for the following will not apply towards the satisfaction of Your share of the Out-of-Pocket Maximum shown in the Schedule of Benefits and will never be paid at 100%:

- Any charge which is not eligible under the Plan.

MAXIMUM OUT-OF-POCKET LIMIT: The yearly amount the federal government sets as the most each Individual or Family can be required to pay in Cost Sharing during the Calendar Year for Covered Services that were performed in the Network.

ANNUAL DOLLAR LIMITS: Plan benefits that are not defined as Essential Health Benefits may have annual dollar limits.

LIFETIME DOLLAR LIMITS: Plan benefits that are not defined as Essential Health Benefits may have a Lifetime dollar limit.

ELIGIBLE MEDICAL EXPENSES

AN ELIGIBLE EXPENSE IS CONSIDERED INCURRED ON THE DATE THE MEDICAL CARE, SERVICES, OR SUPPLIES ARE PROVIDED.

SUBJECT TO THE EXCLUSIONS, LIMITATIONS, DEFINITIONS AND REQUIREMENTS OF THIS PLAN, NEGOTIATED FEES OF NETWORK PROVIDERS, AND USUAL, CUSTOMARY AND REASONABLE CHARGES FOR SERVICES AND SUPPLIES PROVIDED BY NON-NETWORK PROVIDERS, MEDICAL EXPENSES ARE ELIGIBLE FOR PAYMENT UNDER THIS PLAN ONLY IF THEY ARE:

1. Administered or ordered by a Physician; and

2. Medically Necessary for the diagnosis and treatment of an Illness or Injury unless otherwise specifically excluded as an Eligible Expense; and

3. Not excluded under any provision or section of this Plan.

ELIGIBLE MEDICAL EXPENSES ARE LIMITED TO:

1. Benefits payable for Inpatient Hospital confinement when Medically Necessary for the treatment of a covered Illness or Injury. Eligible Hospital expenses include:

   - Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit (when deemed Medically Necessary).
   - Medically Necessary services and supplies furnished by the Hospital, including Hospital Miscellaneous Expenses.
   - Special purpose rooms, such as operating room, maternity delivery room and recovery room.

   For purposes of determining Plan benefits, a stay in a Hospital observation unit will be considered an Outpatient Hospitalization subject to the Plan provisions and benefit limitation.

2. Benefits payable for Inpatient and Outpatient Residential Treatment for Mental Health and/or Substance Abuse conditions. Eligible Residential Treatment expenses include:

   - Daily Room and Board and general nursing services at a Residential Treatment Facility when deemed necessary and meet Medical Necessity standards in the appropriate level of care.
   - The treatment is provided by a Residential Treatment Facility that is established and operated in accordance with state and federal law;
   - The treatment is subject to Precertification, Plan approval, Utilization Management and concurrent reviews.
   - Medically Necessary services and supplies furnished by the Residential Treatment Facility, including Inpatient/Outpatient miscellaneous services and supplies.

3. Charges made by a Child Birthing Center including Room and Board, miscellaneous, lab work, professional fees, delivery, facility use, supplies, prenatal and postpartum care and exams.

4. Charges made by an Ambulatory Surgical Center, Minor Emergency Medical Clinic or Urgent Care facility.

5. Charges made for Home Health Care Services that are Medically Necessary up to the maximum shown in the Schedule of Benefits for services that are for the care and treatment of a covered Illness or Injury furnished to a Covered Person at his or her place of residence. (Please see the section entitled "Description of Medical Benefits" for further details.)

6. Charges made for Inpatient or Outpatient Hospice Care, including Semi-Private Room and Board if provided on an Inpatient basis; end of life counseling and bereavement counseling for an Individual with a Terminal Illness and his or her Family; and medical social services. (Please see the section entitled "Description of Medical Benefits" for further details.)

7. Charges made by a Skilled Nursing Facility during a Convalescent Period up to the maximums shown in the Schedule of Benefits including charges for Room and Board and general nursing services. (Please see the section entitled "Description of Medical Benefits" for further details.)

8. Expenses for the services of a legally qualified Physician for medical care and/or surgical treatment.

9. Fees of a Registered Nurse (R.N.) for private duty nursing services only when ordered by a Physician. (Please see the section entitled "Description of Medical Benefits" for further details.)

10. Charges for professional Ambulance service to the appropriate facility where Emergency Services are rendered or to the appropriate facility where the Covered Person may be transferred for care. Air Ambulance is covered only when terrain, distance or the Covered Person's condition warrants. Ambulance charges for convenience are not covered.

11. Charges for diagnostic X-ray and laboratory tests, electrocardiograms (EKG), electroencephalogram (EEG), pneumoencephalograms, basal metabolism tests, MRI's, CT scans or similar well established diagnostic tests generally approved by Physicians throughout the United States (“Diagnostic Testing”).

12. Charges for radiation therapy and chemotherapy.

13. Charges for physical therapy and/or rehabilitation services if related to a covered Illness or Injury.

14. Fees of a legally qualified Physician or qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to a covered Illness or Injury other than a functional nervous disorder, or due to Surgery performed on account of a covered Illness or Injury. If the speech loss is due to Congenital Anomaly, Surgery to correct the anomaly must be performed prior to the therapy.

15. Expenses for occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Illness and improve a body function. Eligible Expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

16. Expenses for respiratory therapy by a licensed therapist for which measurable improvement is expected within a reasonable period of time.

17. Expenses for allergy testing, injections and serum, when rendered by a Physician or other Provider.

18. Charges for the cost, processing and administration of blood or blood components.

19. Charges for anesthetics and their administration, except where Surgery is not covered.

20. Charges for Cosmetic Surgery and Plastic Surgery shall be payable as other Surgeries ONLY if the following conditions exist:

    - Surgery is for the correction of conditions resulting from accidental injuries or traumatic scars from birth;
    - Surgery is for the correction of Congenital Anomalies and treatment must be necessary to correct a body function; or
    - Surgery is for reconstruction to correct deformities resulting from Medically Necessary Surgery, due to malignancy or fibrocystic disease.

    In accordance with the Women’s Health and Cancer Rights Act of 1998, reconstructive breast Surgery benefits are provided for:

    - Reconstruction of the breast on which a mastectomy has been performed,
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
    - Coverage of the prostheses and physical complications during all stages of a mastectomy, including lymphedemas.

    These benefits are provided in a manner determined in consultation with the attending Physician and the patient. Must be Precertified by the Utilization Management Department.

21. Charges for medical supplies including but not limited to: dressings, sutures, casts, splints, trusses, crutches, colostomy bags, catheters, syringes and needles for administering covered drugs, medicines or insulin (including glucometers) when not an Eligible Expense under the Prescription Drug Benefit. Replacements will only be covered if Medically Necessary and not as the result of loss, theft, or damage.

22. Charges for the rental or purchase (whichever is less) of Durable Medical Equipment prescribed by a Physician; wheelchair, Hospital bed or other Durable Medical Equipment required for therapeutic use. Replacements will only be covered if not the result of loss, theft, or damage.

23. Expenses for a wig or artificial hairpiece following cancer treatment or alopecia related to medical condition.

24. Charges for prostheses and Orthotic Appliances; artificial limbs, eyes, pacemakers, larynx, cervical collars, braces; breast prostheses to include special bras; orthotics prescribed for Full-Time wear; corrective shoes; and first lens after cataract Surgery, when Medically Necessary. Replacements will only be covered if Medically Necessary and not as the result of loss, theft, or damage.

25. Charges made for voluntary sterilization, but not their reversal.

26. Charges for contraceptive management.

27. Expenses in connection with fertility studies or sterility studies, beyond the period necessary to diagnose the condition, including Physician services and ultrasound. (limited to treatment of medical conditions only)

28. Charges for services and supplies in connection with non-Experimental organ and tissue transplant procedures. (Please see section entitled "Description of Medical Benefits" for further details.)

29. Charges for Genetic Testing are Eligible Expenses under Your Plan. Precertification is required for both Network and Non-Network Genetic Testing and is subject to Medical Necessity determinations. Plan approval is required prior to services being rendered.

    Requests for Precertification will not be accepted from laboratories performing Genetic Testing. There are times when a Provider may utilize the services of a Non-Network laboratory when ordering Genetic Testing services; it is the responsibility of the Provider who is ordering the testing to obtain Precertification. (Please see the section entitled “Description of Medical Benefits” for further details.)

30. Charges for dental services provided by a dentist, oral surgeon or Physician, including all related charges for repair to sound natural teeth due to an accidental Injury, domestic violence, or a medical condition (including) both physical and Mental Health conditions, in order to restore them to their condition prior to such accident; bony/partial extractions, tumors and cysts. Charges for Hospital expenses in connection with dental services will also be covered, but only if it is deemed Medically Necessary for the Covered Person to be treated in or confined in a Hospital, due to a medical condition which could jeopardize the Individual’s life if the services were not rendered in a Hospital.

31. Charges for services, including related X-rays, to detect and/or correct (by manual or mechanical manipulation) structural imbalance, distortion or subluxation in the human body for the removal of nerve interference, when the nerve interference is the result of or related to such problems in the vertebral column or musculoskeletal. Charges made by a Chiropractor for benefits that exceed the maximum specified in the Schedule of Benefits and/or is determined to be for maintenance, palliation, or excessive care are not considered Eligible Expenses.

32. Charges for treatment of kidney disorders by hemodialysis or peritoneal dialysis.

33. Expenses for Preventive Health Services.

34. Expenses for Well Baby/Child Care for services or supplies rendered to a newborn or child up to the age limitation specified in the Schedule of Benefits, solely for the purpose of health maintenance and not for the treatment of an Illness or Injury (including Physician office visits and standard and appropriate periodic checkups and immunizations).

35. Eligible Expenses in connection with treatment of Temporomandibular Joint Dysfunction or Derangement (TMJ), including diagnostic services, and treatment. Not including orthodontic or dentofacial orthopedic appliances and adjustment thereto. Eligible Expenses for Temporomandibular Joint Dysfunction or Derangement are covered as any other Illness.

36. Eligible Expenses for sleep lab, which are Medically Necessary and approved by Utilization Management.

37. Charges for all equipment, supplies, and diabetes Outpatient self-management training and educational services used to treat diabetes, if the Covered Person's treating Physician or a Physician who specializes in the treatment of diabetes certifies that such services are Medically Necessary. To be considered as a Covered Service, diabetes Outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist.

38. Expenses for educational training, instruction or educational materials that are Medically Necessary and Prior Authorized by the Utilization Management Department.

39. Charges for nutritional counseling provided by a licensed dietitian, except for expenses, services, treatment, and Medications that are related to weight control.

40. Eligible Expenses for tobacco cessation counseling (see Schedule of Medical Benefits) and drug aides (See Schedule of Prescription Drug Benefits).

41. Eligible Expenses for massotherapy, when rendered by a Licensed Physical Therapist or Medical Doctor.

42. Eligible Expenses for Audiology exam, fittings and hearing aids up to a maximum of $3,000 every four (4) years.

DESCRIPTION OF MEDICAL BENEFITS

THE FOLLOWING PARAGRAPHS FURTHER DESCRIBE THE MEDICAL BENEFITS PROVIDED UNDER THE PLAN.

CARDIAC REHABILITATION: Phase I begins approximately two (2) to four (4) days following a heart attack, or twenty-four (24) hours post-heart Surgery. Patients are assisted through range of motion exercises, which gradually progress to walking or stair climbing by the time of discharge.

Phase II is an Outpatient Hospital based program, usually of (two) 2 to three (3) month's duration. Patients engage in a monitored program of exercise therapy, health education and individualized or group support sessions.

Phase III is an Outpatient exercise program held at various community fitness facilities. Patients engage in conditioning activities supervised by a Registered Nurse and an exercise physiologist. **Phase III is not a Covered Expense.**

EMERGENCY CARE SERVICES: In the event of an Emergency, go to the nearest Hospital or immediate care facility for immediate care or dial 9-1-1 for Emergency assistance. An Emergency Medical Condition is any medical condition that is severe enough to cause a prudent layperson with an average knowledge of health and medicine to believe that absence of immediate medical attention could result in any of the following:

1. Placing the health of the Individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

2. Serious impairment to bodily functions;

3. Serious dysfunction of any bodily organ or part.

Emergency Services will be covered according to Your Schedule of Benefits without regard to the day, time, or location that the Emergency Services are rendered.

This Plan covers Emergency Services for an Emergency Medical Condition treated in any Hospital Emergency department. The Plan will not require Precertification or impose any other administrative requirements or benefit limitations that are more restrictive if Emergency Services are received from a Non-Network Provider. However, a Non-Network Provider of Emergency Services may send the Covered Person a bill for any charges remaining after the Plan has paid (this is called "balance billing").

The Plan will apply the same Cost Share for Non-Network Emergency Services as it generally requires for Network Emergency Services.

The UCR for Non-Network Emergency Services will be the greatest of the following:

1. The amount negotiated with Network Providers/Affiliates for the Emergency Services furnished;

2. The amount for the Emergency Services calculated using the same method the Plan generally uses to determine payments for Non-Network services, but substituting the Network Cost Share provisions for the Non-Network Cost Share provisions; or

3. The amount that would be paid under Medicare for the Emergency Services.

GENETIC TESTING: The Plan pays for Genetic Testing that is conducted to analyze chromosomes, genes or proteins, the results of which provide genetic information that is used to diagnose or treat a disease. Genetic Testing is only covered with Precertification, when Medically Necessary, and when the test results are used to diagnose or treat a covered medical condition of a Covered Person. Genetic Testing is not covered in any of the following circumstances:

- The testing is not performed by a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory;
- The testing is a population screening without a personal or Family history, with the exception of Precertified preconception or prenatal screening for certain conditions such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies;
- The testing is for informational purposes alone; or

- The testing is considered Experimental or investigational.

Genetic Testing may be accompanied by pre-test and post-test counseling if such counseling is Precertified by the Utilization Management Department.

HOME HEALTH CARE SERVICES: Covered Services are those performed by a Home Health Care Agency or other Provider in Your residence. Home Health Care Services includes professional, technical, health aide services, supplies, and medical equipment. Prior Authorization of services and a treatment plan will be required to determine whether Home Health Care Services are Medical Necessity and covered by the Plan as determined by the Plan. Covered Persons must be confined to the home for medical reasons, and physically unable to obtain medical services on an Outpatient basis in order for Home Health Care Services to be covered. Covered Services, subject to Prior Authorization, include but are not limited to:

1. Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).

2. Medical/Social Services.

3. Diagnostic Services.

4. Nutritional Guidance.

5. Home Health Aide Services. The Covered Person must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by The Third Party Administrator, and their duties must be assigned and supervised by a professional Nurse on the staff of the Home Health Care Provider.

6. Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.

7. Medical/Surgical Supplies.

8. Durable Medical Equipment.

9. Prior Approved Prescription Drugs.

10. Private Duty Nursing.

11. Certain Home Health Care Services may be approved at the discretion of AultCare when the patient is not confined to the home.

Non-Covered Services include but are not limited to:

1. Food, housing, homemaker services and home delivered meals.

2. Home or Outpatient hemodialysis services (unless covered under Therapy Services).

3. Physician charges.

4. Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices).

5. Services provided by Registered Nurses and other health workers who are not acting as Employees or under approved arrangements with a contracting Home Health Care Provider.

6. Services provided by a member of the patient’s immediate family.

7. Services provided by volunteer Ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

8. Services that are otherwise excluded or not covered by this Plan Document and Summary Plan Description.

Home infusion therapy will be paid only if You obtain Prior Authorization for such therapy. Benefits for home infusion therapy include a combination of nursing, Durable Medical Equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home Infusion therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Home infusion therapy Site of Care
Infusion therapy can be given in the Hospital or in an Outpatient setting as alternative Sites of Care, subject to Prior Authorization. Review for Medical Necessity of select IV and injectable therapy services will include determination of the Medical Necessity of the appropriate Site of Care (location for Your infusion). Infusion therapy given at a Site of Care that is not appropriate taking into account the availability of other Sites of Care will not be covered as determined by the Plan. Prior Authorization of the Site of Care is required. Options may include homecare, an ambulatory infusion center, or a Physician office.

With Prior Authorization, non-hospital facility Preferred Sites of Care may include:

- Physician's office
- Infusion Center
- Home

With Prior Authorization, Non-Preferred Sites of Care include:

- Hospital Outpatient setting

Non-hospital Outpatient setting alternative Sites of Care are the Preferred sites of service for Medications addressed in this Plan Document.

Medications reviewed under the Site of Care policy are considered not Medically Necessary if administered in an unapproved Hospital Outpatient setting when an approved Site of Care is a treatment option. All non-approved doses shall be billed through a non-hospital facility or accept non-hospital facility reimbursement.

HOSPICE CARE: The Plan pays for the following Hospice Care charges on a Usual, Customary and Reasonable basis when a Covered Person's Physician certifies that he has a Terminal Illness which requires Hospice Care:

1. Charges made by an Inpatient hospice facility for Palliative Care but not to exceed the Usual, Customary and Reasonable Semi-Private room rate charged by a Hospital;
2. Charges made for Outpatient Hospice Care through a centrally administered, medically directed and Nurse coordinated program which a) provides an organized system of home care; and b) uses a Hospice Team, and; c) is available twenty-four (24)-hours-a-day, seven (7)-days-a-week;
3. End of life counseling and bereavement counseling for the terminally ill Covered Person and his covered Family;
4. Medical social services, including:
   - Assessment of the social and emotional factors related to the Covered Person's Terminal Illness, need for care, response to treatment, and adjustment to care; and
   - Action to obtain casework services to assist in resolving problems in these areas; or
5. Pastoral counseling, other than counseling provided by a licensed pastoral counselor to a member of his congregation in the course of duties to which he has been called as a pastor or minister.

Must be Precertified by the Utilization Management Department.

Charges not covered under Hospice Care:

1. End of life counseling and bereavement counseling which is not provided by or through the hospice program of care; or

2. Services provided by homemakers, caretakers and the like; or

3. Funeral services and arrangements; or

4. Curative treatment or services; or

5. Services and supplies that are not for the palliation or management of Terminal Illness.

HOSPITAL BENEFITS: Benefits are payable for Inpatient Hospital confinement when Medically Necessary for the treatment of a covered Illness or Injury. Eligible Hospital expenses include:

- Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit (when deemed Medically Necessary).
- Medically Necessary services and supplies furnished by the Hospital, including Hospital Miscellaneous Expenses.
- Special purpose rooms, such as operating room, maternity delivery room and recovery room.

For purposes of determining Plan benefits, a stay in a Hospital observation unit will be considered an Outpatient Hospitalization subject to the Plan provisions and benefit limitation.

Successive periods of Hospital confinement shall be considered one period of confinement, unless as an Employee You return to work on a Full-Time basis, or as a Dependent, a subsequent confinement is separated by a period of at least three (3) months.

Benefits are also payable for charges made by a Hospital facility for services such as, but not limited to, Outpatient services, Emergency Services for the treatment of an Illness or Injury, observation room, minor Surgery, Diagnostic Testing, or therapy services.

MENTAL HEALTH AND/OR SUBSTANCE ABUSE: Mental Health and/or Substance Abuse benefits provide coverage for the diagnosis and treatment of mental Illnesses, and Substance Abuse and addiction, on the same terms and conditions as those provided for the treatment of physical disorders. Full parity is applied to all existing Mental Health and/or Substance Abuse benefits to allow for all Mental Health and/or Substance Abuse diagnoses and services to be covered as equal to those benefits for medical and surgical services.

If this Plan offers prescription drug services, the coverage shall include prescription drug services for the treatment of Mental Health and/or Substance Abuse on the same terms and conditions as other physical diseases and disorders.

Requests for opioid dependence treatment at any level of care throughout the continuum will be handled as an expedited review. To view options regarding opioid education, disposal sites, and educational material, visit the Pharmacy page on the AultCare website at www.aultcare.com. Education material is also available by clicking the link available on the website: https://www.cdc.gov/drugoverdose/patients/materials.html. Covered Persons will also receive patient focused educational material on opioid therapy at the pharmacy.

ORGAN TRANSPLANTS: The Plan will pay for services and supplies in connection with non-Experimental organ and tissue transplant procedures, subject to the following conditions:

1. If the donor is covered under this Plan, Eligible Expenses incurred by the donor will be considered for benefits.
2. If the recipient is covered under this Plan, Eligible Expenses incurred by the recipient will be considered for benefits. Expenses which are related to the donation and are incurred by the donor, who is not ordinarily covered under this Plan according to the Plan's eligibility requirements, will be considered Eligible Expenses to the extent that such expenses are not payable by the donor's coverage.
3. If both the donor and the recipient are covered under this Plan, Eligible Expenses incurred by each Covered Person will be treated separately for each Covered Person.

4. The Usual, Customary and Reasonable cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered an Eligible Expense.
5. Transportation, meals, and lodging cost shall not exceed $10,000 for recipient, if covered under this Plan, and one other individual. If the covered recipient is a minor, the $10,000 for transportation, meals and lodging cost is extended to include both parents.

However, in reference to items above, if the Plan's expenses for the transplant are covered by a separate transplant contract with the Hospital in which the transplant occurs, and such contract contains a global case fee which includes the cost of the donor's Eligible Expenses, then all Eligible Expenses will be payable for the donor under this Plan and will not be coordinated with the donor's plan.

PRE-ADMISSION TESTING: Charges for pre-admission testing are covered under the Plan for X-rays and other tests as shown in the Schedule of Benefits when such testing is performed on an Outpatient basis prior to an Inpatient confinement or Outpatient Surgery.

The pre-admission testing benefit will only be paid for X-rays and other tests performed after the date the Physician schedules the Surgery.

PREGNANCY BENEFITS: Benefits for Pregnancy are treated as any other Illness under the Plan for Covered Persons.

Routine Nursery care for a newborn child is covered as any other Illness, provided the child is enrolled for coverage under this Plan within the time period specified under the section entitled "Dependent Enrollment". This benefit is to cover Hospital or Child Birthing Center charges incurred at the time of birth and circumcision.

Newborns' and Mothers' Health Protection Act
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or for the newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider (for example, Your Physician), after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours or ninety-six (96) hours as applicable.

In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to forty-eight (48) hours or, of up to ninety-six (96) hours for a caesarean section. For further information, please refer to the "Precertification" section of Your booklet for the paragraph entitled "Pregnancy" or contact Your Plan Administrator.

PREVENTIVE HEALTH SERVICES: The Plan provides coverage for Preventive Health Services without any Cost Sharing when these services are rendered by a Network Provider.

Preventive Health Services are services as defined under federal law (PPACA) and related regulations as including (1) evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved, (2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control with respect to the individual involved, (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, (4) With respect to women, to the extent not described in above, preventive care and screenings include those provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration and developed in accordance with 45 CFR 147.130(a)(1)(iv).

Certain Preventive Health Services are paid at 100%, but once a diagnosis is made, the benefits are paid with Copayments, Deductibles, and Coinsurance, as specified in the Plan. The benefit determination is based on how Your Provider bills the claim.

Please contact the Third Party Administrator at www.aultcare.com or 1-800-344-8858 if You have any questions or need to determine whether a service is eligible for coverage as a Preventive Health Service. For a comprehensive list of recommended Preventive Health Services, please visit **https://www.healthcare.gov/preventive-care-benefits/**

PRIVATE DUTY NURSING: Services of a practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), when ordered by a Physician, are covered. Nursing services do not include care which is primarily non-medical or Custodial in nature such as bathing, exercising, feeding, personal grooming, and administration of oral Medications.

Home services are covered if an R.N. or L.P.N.'s continual skills are needed. Benefits are not provided for a Nurse who usually lives in the Covered Person's home or is a member of the Covered Person's immediate Family.

Must be Precertified by the Utilization Management Department.

BENEFITS AND REQUIREMENTS SPECIFIC TO PUBLIC EMPLOYER PLANS: The Plan provides coverage for the following benefits but only if the Plan is a Non-Federal Public Employer Benefit Plan:

1. **Routine Patient Care During a Cancer Clinical Trial.** The Plan will cover routine patient care to the extent required by Ohio law administered to a Covered Person participating in any stage of an eligible cancer clinical trial if that care would be covered under the Plan if the Covered Person was not participating in a clinical trial. An eligible cancer clinical trial must meet all the following criteria:

    a. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes;
    b. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes;
    c. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;
    d. The trial does one of the following:

        i. Tests how to administer a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
        ii. Tests responses to a health care service, item, or drug for the treatment of cancer;
        iii. Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care Services, items, or drugs for the treatment of cancer;
        iv. Studies new uses of a health care service, item, or drug for the treatment of cancer; and

    e. The trial is approved by one of the following entities:

        i. The National Institutes of Health or one of its cooperative groups or center under the United States Department of Health and Human Services;
        ii. The United States Food and Drug Administration; or
        iii. The United States Department of Defense or Department of Veteran's Affairs.

2. **Orally Administered Cancer Medications.** Please note that orally administered cancer Medication coverage shall be no less favorable than coverage for intravenous and injected cancer Medications in accordance with state law if the Cost Sharing imposed under the Plan exceeds one hundred dollars ($100) per prescription fill for orally administered cancer Medication.

3. **Precertification of Prescription Drugs for Chronic Conditions**. We shall honor Precertification for a Covered drug to treat a chronic condition for the lesser of twelve months or the last day of the Covered Person's eligibility under the Plan, except for the following:

    a. Drugs that are prescribed for a non-maintenance condition;
    b. Drugs that have a typical treatment of less than one year;
    c. Drugs that require an initial trial period to determine effectiveness and tolerability, beyond which a one-year, or greater, Precertification period will be given;
    d. Drugs where there is medical or scientific evidence do not support a twelve-month prior approval;
    e. Drugs that are a schedule I or II controlled substance or any opioid analgesic or benzodiazepine; or
    f. Drugs not prescribed by an In-Network Provider as part of the care management program.

    Notwithstanding the foregoing, We may terminate a Precertification for a drug used to treat a chronic condition if the condition changes or there are changes to state or federal laws or guidance that the drug is no longer approved or safe for the intended purpose.

4. **Retrospective Review of Claims Subject to Precertification**. Upon written request, We shall permit a Retrospective Review for a claim that is submitted for a Covered Service where Precertification was required but not obtained if the service in question meets all of the following:

    a. The service is covered by the Plan;
    b. The service is directly related to another service for which Precertification has already been obtained and that has already been performed;
    c. The new service was not known to be needed at the time the original Precertification was performed; or
    d. The need for the new service was revealed at the time the original Precertification service was performed.

    Once the written request and all necessary information is received, We shall review the claim for coverage and medical necessity. We shall not deny a claim for such a new service based solely on the fact that a Precertification was not received for the new service in question.

5. **Precertification of Opioid Analgesics**

    Covered Opioid analgesics prescribed for treatment of chronic pain are subject to Precertification except when the Covered Person is in hospice care, is being treated for a terminal condition, or has cancer or a history of cancer.

6. **Medication Synchronization**

    The Plan will cover a prescription drug subject to medication synchronization when the drug is dispensed in a quantity or amount that is less than a thirty-day supply if all of the following conditions are met:

    a. The Covered Person elects to participate in medication synchronization;
    b. The Covered Person, the prescriber, and the pharmacist at a Network Pharmacy agree that medication synchronization is in the best interest of the Covered Person; and
    c. The prescription drug to be included in the Medication Synchronization meets all of the following requirements:
        i. It is covered by the Plan;
        ii. It is prescribed for the treatment and management of a chronic disease or condition and is subject to refills;
        iii. It satisfies all relevant Precertification criteria;
        iv. It does not have quantity limits, dose optimization criteria, or other requirements that would be violated if synchronized;
        v. It does not have special handling or sourcing needs, as determined by Plan, that require a single, designated pharmacy to fill or refill the prescription;
        vi. It is formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization; and
        vii. It is not be a schedule II controlled substance, opiate, or benzodiazepine.

    "Medication synchronization" means a pharmacy service that synchronizes the filling or refilling of prescription drugs in a manner that allows the dispensed drugs to be obtained on the same date each month. Notwithstanding the foregoing, the Plan's Authorization for medication synchronization applies only once for each prescription drug subject to medication synchronization for the same Covered Person, except when the prescriber changes the dosage or frequency of administration of the prescription drug subject to medication synchronization or the prescriber prescribes a different drug.

RESIDENTIAL TREATMENT OF MENTAL HEALTH AND/OR SUBSTANCE ABUSE CONDITIONS: Payment may be made for daily charges for Room and Board and general nursing services in an Inpatient or Outpatient Residential Treatment Facility that is accredited by the Centers for Medicare and Medicaid Services (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., (or any successor organization) as a Hospital that meets the requirements of the respective jurisdiction as either a Hospital or mental/behavioral health care facility. If levels of care other than residential care are offered and being provided to the Covered Person, the facility's accreditation must include those services in addition to residential care. A free-standing facility that is not a part of a Hospital may not qualify as a Hospital Facility for

purposes of Inpatient treatment. Check with the Utilization Management Department at the time of Precertification and Plan approval.

ROUTINE PHYSICALS: Routine physical exams performed by a Network Provider are payable without Copayments or Deductibles to the extent the services constitute Preventive Health Services; other services billed separately are payable as specified in the Schedule of Benefits.

SKILLED NURSING FACILITY: Payment is to be made for daily charges for Room and Board and general nursing services in a licensed, Skilled Nursing Facility, based on the daily room benefit of the Skilled Nursing Facility's Semi-Private room rate, up to the maximums shown in the Schedule of Benefits ; subject to the Covered Person's stay being Precertified by the Utilization Management Department. Ongoing review to determine Medical Necessity for continued care in a Skilled Nursing Facility will be required by the Utilization Management Department.

A Convalescent Period is a period of time beginning with the date of confinement by a Covered Person to a Skilled Nursing Facility. Both the Hospital and convalescent confinement must be for the care and treatment of the same Illness or Injury. Custodial Care is not covered.

SURGICAL BENEFITS: Surgical benefits are provided for operations resulting from an Illness or Injury. If the Physician charges for two or more surgical procedures performed during a single operative session, the Usual, Customary and Reasonable charge for each procedure will be determined.

WELL BABY/CHILD CARE: "Well Baby/Child Care" means medical treatment, services or supplies rendered to a newborn or child up to the age limitation specified in the Schedule of Benefits.

MEDICAL EXCLUSIONS AND LIMITATIONS

THE FOLLOWING ARE NOT ELIGIBLE EXPENSES UNDER THE PLAN; HOWEVER, CERTAIN CHARGES MAY BE ELIGIBLE UNDER THE PLAN'S DENTAL, VISION OR DRUG BENEFITS.

1. Expense incurred in connection with services or supplies which are not Medically Necessary for the treatment of an Illness or Injury (except for Preventive Health Benefits);

2. Expenses for services which are not recommended, approved or provided by a Physician;

3. Expenses, services, treatments, and Medications that are related to weight control, such as weight loss programs and dietary consultations. Gastric restrictive procedures are covered only when deemed Medically Necessary and the procedure has been Precertified by the Utilization Management Department;

4. Expenses for deluxe or luxury items; air conditioners, purifiers; dehumidifiers, corrective shoes, heating pads, hot water bottles, exercise equipment, whirlpools, waterbeds, and other clothing and equipment which is not medical in nature regardless of the relief they provide for an Illness or Injury;

5. Expenses for any confinement in an institution primarily to change one's environment;

6. Expenses for custodial or domiciliary care; supervised living or halfway houses; services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled or outward bound programs, even if psychotherapy is included; services related to non-compliance of care if You end treatment against the medical advice of the Provider; marital and sexual counseling/therapy; wilderness camps;

7. Expenses for Telemedicine including telephone and internet consultations (Physician office visits, consultations, treatment and anything related to telecommunication technologies);

8. Expenses for mailing, sales tax, preparing reports, preparing itemized bills, or completing claim forms unless specifically outlined in the Schedule of Benefits;

9. Any charges incurred for Experimental treatment or drugs, except for Plan approved participation in Clinical Trials;

10. Any expense for Cosmetic Surgery and/or Plastic Surgery except when due to a) a Congenital Anomaly of a covered newborn or for a covered child if the procedure was delayed due to Medical Necessity; or b) an Injury; or c) the surgical removal of all or part of the breast tissue solely because of an Illness or Injury to the breast to include Surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complication at all stages of the mastectomy, including lymph edemas; or d) for Plastic Surgery as necessary for the prompt treatment of a diseased condition;

11. Any services, treatment, or supplies intended to prevent hair loss or induce hair growth;

12. Any expenses related to Custodial Care, sanitarium care, rest care, or charges made by a Hospital for a confinement primarily for physiotherapy or hydrotherapy;

13. Any expenses for eyeglasses, correction of vision for the purpose of refraction, radial keratotomy or radial keratoplasty, fitting of glasses or eye examinations, except for the first pair of glasses or lenses prescribed as a result of a) cataract Surgery or b) an accidental Injury or c) the first pair of lenses prescribed as a therapeutic treatment of keratoconus;

14. Expenses or treatment for foot care for flat foot conditions, the treatment of subluxation of the foot, care or removal of corns, care of bunions (except capsular or bone Surgery), care or removal of calluses, care or removal of toe nails, treatment for fallen arches, weak feet and chronic foot strain. Charges for the cutting or removal of corns, calluses or toenails will be covered when an underlying medical condition such as diabetes or hardening of the arteries has been diagnosed;

15. Expenses related to the treatment of infertility, procedures and Medications to restore or enhance fertility;

16. Expenses related to artificial insemination and in vitro fertilization;

17. Expenses related to sex change procedures, gender dysphoria, or impotence (unless impotency is due to an organic Illness or as a result of a covered Surgery);

18. Charges for, or related to, Pregnancy of a surrogate mother;

19. Expenses related to Attention Deficit Disorder (ADD), beyond the period necessary to diagnose the condition, except charges for medical treatment and Medication management;

20. Any expenses for charges made by a counselor, Psychologist, or Psychiatrist for the treatment of functional nervous disorders (such as learning disorders, autism, mental retardation, or senility) beyond the period necessary to diagnose the condition, except charges for medical treatment and Medication management;

21. Any expenses related to counseling for "Transient Situational Adjustments" (such as marital problems, Family problems, behavioral problems, or social problems) unless such counseling is necessary for the treatment of a diagnosed Mental and/or Nervous Disorder;

22. Charges made for reversal of voluntary sterilization;

23. Expenses for vitamins or nutrition supplements, unless covered under Preventive Health Services;

24. Oriental pain control or acupuncture;

25. Dental services or dental supplies of any kind except those specifically shown as an eligible medical expense under this Plan;

26. Any expenses for occupational, speech or orthopedic therapy or training unless related to a covered Illness or Injury;

27. Any expenses for biofeedback or hypnosis;

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

29. Any charges for any condition, Disability or expense resulting from or sustained as a result of being engaged in an illegal occupation, commission of or attempted commission of an assault or a felonious act or aggravated assault;

30. 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;

31. Workers' Compensation and Injuries at Work Exclusions;

    - Charges covered under any Workers' Compensation Law or similar law.
    - Injuries at work if Workers' Compensation is available, required, or applicable, regardless of whether Workers' Compensation claim is filed.
    - Charges for You, Your Dependents or Spouse for a work related Injury while self-employed.

    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.

32. Any expense for services performed by a person who ordinarily resides in the Covered Person's household or who is related to the Covered Person;

33. 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;

34. Any expense which exceeds the Usual, Customary and Reasonable expense for the care rendered;

35. Travel expenses of a Physician or travel expenses of a Covered Person, even if recommended by a Physician, unless specifically shown as an "Eligible Medical Expense";

36. Charges incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical service, drugs, or supplies;

37. Elective abortions;

38. Charges made by a massotherapist;

39. Expenses incurred by the Covered Person prior to the Effective Date of coverage or after termination of coverage;

40. Charges made for Manipulation Therapy for benefits which are determined to be for maintenance, palliation, or excessive care are not an Eligible Expense;

41. Any shoe insert or device that can be purchased Over-the-counter or alteration to shoes that are not customized to the patient to treat a specific covered diagnosis;

42. Non-emergent Ambulance transportation;

43. Charges in excess of Eligible Expenses or in excess of any specified limitations;

44. Expenses incurred related to Lifetime maintenance performed at home or in a medically unsupervised setting for the treatment of Phase III Cardiac Rehabilitation;

45. Drugs obtained from pharmacies not located in the United States are not covered.

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 and Dependent Coverage: 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.

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 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 of employment, with credit given for part-time Employees who transition to Full-time.

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 or she 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.

Collective Bargaining Plans Only: Coverage shall terminate immediately upon the date of any work stoppage due to strike.

REINSTATEMENT OF COVERAGE: If an eligible Employee's coverage terminates by reason of discharge, voluntary or involuntary 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 or involuntary 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 or involuntary 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 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 EXCLUDED 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. If the Employee has Dependent coverage in effect at the time the Dependent meets the definition of an Eligible Dependent: the date the Dependent becomes eligible; or

2. If the Employee does not have Dependent coverage in effect at the time the Dependent meets the definition of an Eligible Dependent: the date the Dependent is eligible if the Employee makes written application for Dependent coverage on or before the thirty-first (31st) day after the date his Dependent becomes eligible.

Newborn Coverage
A Newborn child will automatically be covered during the first thirty-one (31) days for eligible charges related to an Illness or Injury. However, in order for such a newborn's coverage to continue past the first thirty-one (31) days the Employee must apply for coverage within thirty-one (31) days of the child's date of birth and agree to pay any required contribution.

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:

- Birth or adoption of a child by the Employee or the Employee's spouse;
- Placement in the Employee's or Employee's spouse's care of a foster child;
- The Serious Health Condition of an Employee's spouse, child or parent;
- Your own Serious Health Condition;
- 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
- 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 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 or she must notify the Plan Administrator that he or she elects the extension before the end of the first eighteen (18) months of his or her Continuation period; he or she 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 or she 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 or she cannot revoke his waiver unless he or she 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/herself 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 or her 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 Service Center or from Your Company's Human Resources Department. 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).

When going to a Non-Network Hospital, Provider, or Affiliate, You should obtain an Application for Benefits (Claim Form) from the Customer Service Center or Your Company's Human Resources Department and take it with You to the Hospital/Provider's/Affiliate's office. You may be required to make full payment for services at the time of service and send the claim to the address listed on the back of Your ID card.

PRESCRIPTION DRUGS: Benefits for Prescription Drugs will be payable in accordance with the Schedule of Prescription Benefits.

If You utilize Your prescription drug card, You will not need to submit a claim for reimbursement; however, if You do not utilize the prescription drug card, or You are at a pharmacy that does not accept Your prescription drug card and are requesting reimbursement, You must also attach the original receipts to an Application for Benefits (Claim Form) which must include the name of the person needing the prescription, the prescription number, name of the drug, date of purchase, name and address of the pharmacy, the prescribing Physician and the amount charged and send the claim to the address listed on the back of Your ID card.

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 medical 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 (Precertification) 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 Precertification 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 MEDICAL CLAIMS: Except as otherwise provided herein, upon receipt of a Post-Service medical 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.

TIME LIMITS FOR PROCESSING PRE-SERVICE MEDICAL CLAIMS: The time limits for processing a Pre-Service Claim are set forth in the "Precertification" section of this Plan Document above.

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 Adverse Benefit Determination notice is received 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. A request for an expedited internal appeal related to a Pre-Service Urgent Care Claim may be submitted orally or in writing. In terms of whether a claim is an Urgent Care claim, the Plan Administrator shall defer to any such determination by the attending Provider.

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. Thereafter, the Third Party Administrator shall make a benefit determination, which in the case of an Urgent Care claim shall be made not less than forty-eight (48) hours after the earlier of receipt of additional information from the claimant or the end of the period afforded to the claimant to submit additional information.

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 sixty (60)-days (within ten [10] days for Pre-Service Non-Urgent Care Claims; within forty-eight [48] hours for Pre-Service Urgent Care claims) after such request is received. 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 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 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.

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.

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 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 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 Necessity, appropriateness, health care setting or level of care. If the Independent Review Organization finds that the service does meet Plan requirements for Medical 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 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.

REQUESTING AN EXTERNAL REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION: You must request an External Review within 180 calendar days of receiving notice of the Adverse Benefit Determination from the Internal Review. You, someone acting for You, or Your Doctor or Provider, may ask for an External Review. The Provider must have Your written consent to request a review. You do not need the Provider's permission to request an External Review. You do not have to pay for an External Review.

The Independent Review Organization must give You a decision within thirty (30) calendar days of Your request for a standard External Review. The decision must include:

1. The reasons for the request for the External Review.

2. The rationale for the decision.

3. References to evidence or documentation that was considered.

If the Independent Review Organization finds that the Service is Medically Necessary, the Plan will cover the service. You must pay the applicable Cost Share. If the Independent Review Organization finds that the service is not Medically Necessary, the Plan will not cover the service.

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 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 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.

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 Precertification 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). 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 Customer Service Center at 330-363-6360 or for Covered Members outside the area: 800-344-8858, and a Customer Service Representative will help You. You may also supply the requested information online at www.aultcare.com.

MEDICARE PROVISION

For companies with 100 or more active Employees: if an Employee (other than a retiree) and/or Covered Dependent are under age sixty-five (65), eligible for Medicare Disability, and have medical **COVERAGE** under this Plan, this Plan will pay medical benefits primary to Medicare with the exception of benefits received from Medicare after the first thirty (30) months of End Stage Renal Disease, in which case Medicare will pay primary to this Plan. (If a Covered Person has Medicare coverage for End Stage Renal Disease as of August 5, 1997, this Plan will be primary to Medicare for eligible

charges incurred from the period of August 5, 1997, to the date that the Covered Person has had thirty (30) months of Medicare coverage.)

For companies with fewer than 100 active Employees: if an Employee and/or Covered Dependent are under age sixty-five (65), eligible for Medicare Disability, and have medical coverage under this Plan, Medicare will pay primary to this Plan. These provisions do not necessarily apply to COBRA beneficiaries. See Continuation of Coverage (COBRA).

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 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, 1995 and restated February 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 Medical and Prescription Drug Coverage:	Contributory
Dependent Medical and Prescription Drug Coverage:	Contributory
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.

MEDICARE MODERNIZATION ACT: This Plan is written with the intent to comply with the applicable provisions of the Medicare Modernization Act. The Plan must provide You with an annual notice regarding the Plan’s prescription drug coverage; it must state whether the prescription drug coverage under this Plan is “creditable” or “non-creditable”, as defined in the Medicare Modernization Act. The Plan must also provide this notice to You, upon Your written request. If You are eligible for Medicare and You have questions regarding Your prescription drug coverage under this Plan, please contact Your Employer.

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. 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.

ACCUMULATED DEDUCTIBLE: *"Accumulated Deductible"* means if more than one Covered Person in a Family incurs Eligible Expenses during a Calendar Year and the accumulated Eligible Expenses payable by those individuals exceed the Family Deductible shown in the Schedule of Benefits, the Deductible will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

ACCUMULATED OUT-OF-POCKET: *"Accumulated Out-of-Pocket"* means if more than one Covered Person in a Family incurs Eligible Expenses during a Calendar Year and the accumulated Eligible Expenses payable by those individuals exceed the Family Out-of-Pocket shown in the Schedule of Benefits, the Out-of-Pocket will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

ADVERSE BENEFIT DETERMINATION: An *"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 Necessary or not appropriate.

AMBULANCE: *"Ambulance"* means a specially designed or equipped vehicle which is licensed for transferring the sick or injured. It must have customary patient care, safety, and life-saving equipment, and must employ trained personnel.

AMBULATORY SURGICAL CENTER: *"Ambulatory Surgical Center"* means an institution or facility, either free standing or as part of a Hospital with permanent facilities, equipment and operated for the primary purpose of performing surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered to be an Ambulatory Surgical Center.

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.

BRAND NAME DRUG: *"Brand Name Drug"* means a Medication sold by a pharmaceutical company under a trademark-protected name. Brand name Medications can only be produced and sold by the company that holds the patent for the drug. Brand name drugs may be available by prescription or Over-the-counter.

CALENDAR YEAR: *"Calendar Year"* means a period of time beginning on January 1 and ending December 31 of the same given year.

CHILD BIRTHING CENTER: *"Child Birthing Center"* means an Outpatient facility which meets all of these requirements: It complies with licensing and other legal requirements in the jurisdiction where it is located; it is engaged mainly in providing a comprehensive birth service program to pregnant persons who are considered normal low risk patients; it has organized facilities for birth services on its premises; the birth services are performed by a Physician specializing in obstetrics and gynecology or, at his direction, by a Nurse midwife; it has twenty-four (24) hour a day registered nursing services; and it maintains daily clinical records.

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.)

COMPLICATION OF PREGNANCY: *"Complication of Pregnancy"* means that part of a Pregnancy during which abnormal conditions or concurrent disease significantly affect the Pregnancy's usual medical management. A complication may exist during the Pregnancy; during the delivery; or after the delivery, but a Complication of Pregnancy does not include an elective caesarean section.

CONGENITAL ANOMALY: *"Congenital Anomaly"* means a defective development, abnormality, or malformation of a part of the body which is determined by a Physician to have been present at the time of birth, including cleft lip and cleft palate. Abnormality in this context refers to a medical condition which is contrary to the body's usual size, location, condition, or system and which prevents normal bodily function.

CONVALESCENT PERIOD: *"Convalescent Period"* is a period of time beginning with the date of confinement by a Covered Person to a Skilled Nursing Facility.

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

COSMETIC SURGERY: "*Cosmetic Surgery*" means a procedure that is focused on improving appearance through surgical and medical techniques and can be performed on all areas of the body. Surgery to improve the appearance of any body part is not Medically Necessary and excluded from coverage under the Plan. Cosmetic Surgery and Plastic Surgery are not interchangeable.

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.

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 Medically Necessary treatments, services, drugs, equipment or supplies for an Illness or Injury that are covered and not excluded from coverage under this Plan, subject to the terms, conditions, limitations, restrictions, and requirements of this Plan.

CUSTODIAL CARE: *"Custodial Care*" means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not disabled, in the activities included, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over Medication which can normally be self-administered.

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. A Plan with an overall Deductible may also have separate Deductibles that apply to specific services or groups of service. (Refer to the Schedule of Benefits.)

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.

DIAGNOSTIC TESTING: *"Diagnostic Testing"* means diagnostic X-ray and laboratory tests, electrocardiograms (EKG), electroencephalogram (EEG), pneumoencephalograms, basal metabolism tests, MRI's, CT scans and similar well established diagnostic tests generally approved by Physicians throughout the United States.

DURABLE MEDICAL EQUIPMENT: *"Durable Medical Equipment"* means equipment which is able to withstand repeated use; and used to serve a medical purpose; and not generally useful to a person in the absence of Illness or Injury.

ELIGIBLE EXPENSES: *"Eligible Expenses"* means expenses for Medically Necessary 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 Service is actually provided to an Individual.

EMBEDDED DEDUCTIBLE: *"Embedded Deductible"* means that each member of a Family is looked upon as an Individual in regard to the Deductible. Once a member reaches the Individual Deductible, the Plan's Coinsurance will apply. Any combination of Family members may satisfy the Family Deductible; however, no member may satisfy more than his or her Individual Deductible amount.

EMBEDDED OUT-OF-POCKET: *"Embedded Out-of-Pocket"* means that each member of a Family is looked upon as an Individual in regard to the Out-of-Pocket. Once a member reaches the Individual Out-of-Pocket Maximum, the Plan will begin to pay at 100% of Eligible Expenses for that member. Any combination of Family members may satisfy the Family Out-of-Pocket, at which time the Plan will begin to pay Covered Services at 100% for the entire Family; however, a single member will not be required to satisfy more than his or her Individual Out-of-Pocket amount.

EMERGENCY or EMERGENCY MEDICAL CONDITION: An "*Emergency" or "Emergency Medical Condition"* is any medical condition that is severe enough to cause a prudent layperson with an average knowledge of health and medicine to believe that absence of immediate medical attention could result in any of the following:

1. Placing the health of the Individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES: *"Emergency Services"* means, with respect to an Emergency Medical Condition:

1. A medical screening examination as defined under federal law that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition, and

2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required federal law to Stabilize the patient.

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.

ESSENTIAL HEALTH BENEFITS: *"Essential Health Benefits"* means the definition under federal law (PPACA) as including benefits as in at least the following categories: ambulatory patient services; Emergency Services; Hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care, subject to the State of Ohio benchmark plan. Your Plan may contain some or all of these types of benefits. If Your Plan contains any of these benefits, there are certain requirements that may apply to those benefits.

EXPEDITED REVIEW: *"Expedited Review"* means an External Review conducted no later than seventy-two (72) hours after being assigned to an Independent Review Organization which is initiated for any of the following reasons:

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.

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. We otherwise determine 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.

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 "Medical Benefits".

FAMILY OUT-OF-POCKET: *"Family Out-of-Pocket"* means the total dollar amount spent on Deductibles, Copayments and Coinsurance for Covered Expenses accrued by a Family unit in a Calendar Year.

FULL-TIME: *"Full-Time"* means working a minimum thirty (30) hours per week in the service of the Employer unless hired on a temporary or seasonal basis, as determined by the Employer.

GENERIC DRUG: *"Generic Drug"* (Generic drugs, short: Generics) means a drug defined as "a drug product that is comparable to a Brand/reference listed drug product in dosage form, strength, quality and performance characteristics, and intended use." It has also been defined as a term referring to any drug marketed under its chemical name without advertising.

GENETIC TESTING: *"Genetic Testing"* means testing that is conducted to analyze chromosomes, genes or proteins, the results of which provide genetic information that is used to diagnose or treat a disease. (Please see section entitled "Description of Medical Benefits" for further details.)

HOME HEALTH CARE SERVICES AGENCY: *"Home Health Care Services Agency"* means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a Provider must meet *ALL* of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide Skilled Nursing services and other therapeutic services;

2. It has policies established by a professional group associated with the agency or organization. This professional group must have at least one Physician and at least one Registered Nurse (R.N.) to govern the services provided and it must provide Full-Time supervision of such services by Physician or Registered Nurse;

3. It maintains a complete medical record on each Individual;

4. It has a Full-Time administrator.

HOME HEALTH CARE SERVICES PLAN: *"Home Health Care Services Plan"* means a program for continued care and treatment established and approved in writing by the Covered Person's attending Physician following termination of a Hospital confinement as a resident Inpatient or in lieu of a Hospital confinement, and is for the same or related condition for which he was Hospitalized or would have been Hospitalized. The attending Physician must certify that the proper treatment of the Illness or Injury would require confinement or continued confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Services Plan.

HOSPICE BENEFIT PERIOD: *"Hospice Benefit Period"* means the specified amount of time during which the Covered Person undergoes treatment by a hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminally ill and the Covered Person is accepted into a hospice program.

HOSPICE CARE: *"Hospice Care"* means a prearranged, written outline of the care that will be provided for Palliative Care and management of an Individual's Terminal Illness. Inpatient Hospice Care means treatment certified by the attending Physician that it is Medically Necessary to be received in a facility which may or may not be part of a Hospital and meets all of the following requirements: it complies with licensing and other legal requirements in the jurisdiction where it is located; it is mainly engaged in providing Inpatient Palliative Care for the terminally ill on a twenty-four (24) hour basis under the supervision of a Physician or a Registered Nurse. If the care is not supervised by a Physician, the Inpatient hospice facility must have a Physician available on a prearranged basis; it provides end of life and bereavement counseling; it maintains clinical records on all terminally ill individuals; it is not mainly a place for the aged or a nursing or a convalescent home; and it is approved for payment of Medicare Hospice benefits.

HOSPICE TEAM: *"Hospice Team"* means a group of service Providers who must include at least a Physician and a Registered Nurse (R.N.) but may also include a social worker, counselor, or Psychologist.

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 Necessity. Charges for translation services are not covered under the Plan.

HOSPITAL MISCELLANEOUS EXPENSES: *"Hospital Miscellaneous Expenses"* means the actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

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

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.

INTEGRATED DEDUCTIBLE: *"Integrated Deductible"* means a Deductible with respect to which Eligible Expenses applied to the Network Deductible are also applied to the satisfaction of the Non-Network Deductible and Eligible Expenses applied to the Non-Network Deductible are also applied to the Network Deductible.

INTEGRATED OUT-OF-POCKET: *"Integrated Out-of-Pocket"* means if a combination of Network and Non-Network Providers are utilized, charges applied to the Network Out-of-Pocket will be applied towards the satisfaction of the Non-Network Out-of-Pocket; charges applied to the Non-Network Out-of-Pocket will be applied towards the satisfaction of the Network Out-of-Pocket. In no event will the Eligible Expenses applied to the Calendar Year Out-of-Pocket exceed the Non-Network Calendar Year Out-of-Pocket shown in the Schedule of Benefits.

INTENSIVE CARE UNIT: *"Intensive Care Unit"* means a section, ward, or wing within the Hospital which is separated from other facilities and is operated exclusively for the purpose of providing professional medical treatment for critically ill patients; it has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; it provides constant observation and treatment by Registered Nurses (RNs) or other highly-trained Hospital personnel.

INTERNAL REVIEW: *"Internal Review"* means a review conducted by the Plan, or the Plan Administrator when a Covered Person requests an Internal Review 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.

MAIL ORDER SERVICE or MAIL ORDER PROGRAM: *"Mail Order Service" or "Mail Order Program"* means the Mail Order pharmacy program as identified in this Plan.

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

MEDICAID: *"Medicaid"* means the programs established by Title XIX of the Social Security Amendments of 1965 that provide 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 NECESSARY or MEDICAL NECESSITY: A Health Care Service (including a supply, device, drug, and dental service) is *"Medically 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 Services 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 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.

MENTAL AND/OR NERVOUS DISORDER: *"Mental and/or Nervous Disorder*" means a mental, nervous, or emotional disease or disorder as defined in the standard nomenclature of the American Psychiatric Association.

MINOR EMERGENCY MEDICAL CLINIC: *"Minor Emergency Medical Clinic*" means a freestanding facility, which is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse and a Registered X-ray Technician must be in attendance at all times that the clinic is open. The clinics' facilities must include X-ray and laboratory equipment and a life support system.

For the purpose of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located as an extension of, or in conjunction with, or in any way made part of a regular Hospital shall be excluded from the terms of this definition.

MORBID OBESITY: *"Morbid Obesity"* means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the Physician's standard weight table for a person of the same height, age and mobility as the Plan Covered Person.

NAME BRAND DRUG: *"Name Brand Drug"* (Brand Name Drug) means a Medication sold by a pharmaceutical company under a trademark-protected name. Brand Name Medications can only be produced and sold by the company that holds the patent for the drug. Brand Name Drugs may be available by prescription or Over-the-counter.

NETWORK BENEFIT: *"Network Benefit*" means the benefit to be paid under this Plan for an Eligible Expense when a Covered Service is provided by a Network Pharmacy or Network Provider/Affiliate subject to the terms and conditions of this Plan.

NETWORK ACCUMULATED DEDUCTIBLE: *"Network Accumulated Deductible"* means if more than one Covered Person in a Family incurs expenses during a Calendar Year and the accumulated expenses payable by those Individuals exceed the Network Family Deductible shown in the Schedule of Benefits, the Network Deductible will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

NETWORK ACCUMULATED OUT-OF-POCKET: *"Network Accumulated Out-of-Pocket"* means if more than one Covered Person in a Family incurs expenses during a Calendar Year and the accumulated expenses payable by those Individuals exceed the Network Family Out-of-Pocket shown in the Schedule of Benefits, the Network Out-of-Pocket will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

NETWORK CALENDAR YEAR DEDUCTIBLE: *"Network Calendar Year Deductible*", as shown in the Schedule of Benefits, means the amount of Eligible Expenses which must be incurred by each Covered Person (if applicable) in a Calendar Year before any benefits are payable for Network Eligible Expenses, unless stated otherwise in the Schedule of Benefits.

NETWORK PHARMACY: *"Network Pharmacy"* means an independent pharmacy, a pharmacy within a chain store or a Mail Order Service, which holds a valid participating pharmacy agreement with the Employer's pharmacy benefit manager.

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 SERVICE: *"Non-Covered Service*" means health care treatments, services, drugs, equipment or supplies which are not covered or are excluded, restricted or limited under this Plan.

NON-NETWORK ACCUMULATED DEDUCTIBLE: *"Non-Network Accumulated Deductible"* means if more than one Covered Person in a Family incurs expenses during a Calendar Year and the accumulated expenses payable by those Individuals exceed the Non-Network Family Deductible shown in the Schedule of Benefits, the Non-Network Deductible will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

NON-NETWORK ACCUMULATED OUT-OF-POCKET: *"Non-Network Accumulated Out-of-Pocket"* means if more than one Covered Person in a Family incurs expenses during a Calendar Year and the accumulated expenses payable by those Individuals exceed the Non-Network Family Out-of-Pocket shown in the Schedule of Benefits, the Non-Network Out-of-Pocket will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

NON-NETWORK BENEFIT: *"Non-Network Benefit"* means the benefit to be paid under this Plan for an Eligible Expense when a Covered Service is provided by a Non-Network Pharmacy or Non-Network Provider/Affiliate subject to the terms and conditions of this Plan.

NON-NETWORK CALENDAR YEAR DEDUCTIBLE: *"Non-Network Calendar Year Deductible"* as shown in the Schedule of Benefits, means the amount of Eligible Expenses which must be incurred by each Covered Person (if applicable) in a Calendar Year before any benefits are payable for Non-Network Eligible Expenses, unless stated otherwise in the Schedule of Benefits.

NON-NETWORK PHARMACY: *"Non-Network Pharmacy"* means a pharmacy which does not hold a valid participating pharmacy agreement with the Employer's pharmacy benefit manager.

NON-NETWORK PROVIDER/AFFILIATE: *"Non-Network Provider/Affiliate"* means a Provider of Covered Services, including any Hospital, Physician, Podiatrist, Chiropractor, or allied health practitioner, operating within the scope of his license who does not have a contract with the Plan.

NON-PREFERRED STATUS: *"Non-Preferred Status"* (Non-Preferred) means that the product is not a more cost effective choice within a therapeutic category.

NURSE: *"Nurse*" means a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or a Licensed Practical Nurse (L.P.N.).

ORTHOTIC APPLIANCE: *"Orthotic Appliance*" means an external device intended to correct any defect in form or function of the human body.

OUT-OF-POCKET MAXIMUM: *"Out-of-Pocket Maximum"* means the maximum Cost Share You are required to pay for a Covered Person under the Plan. Once the Out-of-Pocket Maximum is met, the Plan will pay the remaining Eligible Expenses under the Plan for Essential Health Benefits for the remainder of the Calendar Year. (Refer to the Schedule of Benefits.) There can be an Out-of-Pocket Maximum on medical expenses and a separate one for prescription drug expenses, but the two together cannot exceed the Maximum Out-of-Pocket Limit set by the Federal Government.

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.

OUTPATIENT SUBSTANCE ABUSE FACILITY: *"Outpatient Substance Abuse Facility"* means an administratively distinct governmental, public, private or independent unit or part of such unit that provides Outpatient Alcohol and/or Drug Abuse treatment and rehabilitation services and which provides for a Physician who assumes the overall responsibility for coordinating the care of all patients.

PALLIATIVE CARE: *"Palliative Care"* means a course of treatment directed toward lessening or controlling pain. It makes no attempt to cure the Individual's Illness.

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 Health Care Plan, 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 City of Canton. The Plan Sponsor has established the Plan to provide benefits as described herein for 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.

PLASTIC SURGERY: "*Plastic Surgery"* means a procedure that may be covered in situations where a body part does not function properly and the goal is to improve the function of that body part. Plastic Surgery is considered reconstructive in nature. Prior Authorization is required to determine if the requested surgery is to repair the body part that does not function properly due to birth disorders, trauma, burns and disease, or if it is intended to improve appearance. Plastic Surgery and Cosmetic Surgery are not interchangeable.

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

PRECERTIFICATION: *"Precertification*" means the process of obtaining prior approval for any item or service that requires Precertification as set forth in this Plan. See also "Prior Authorization".

PREFERRED STATUS: *"Preferred"* (Preferred) means that the product is a more cost effective choice within a therapeutic category.

PREGNANCY: *"Pregnancy"* means that physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

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

PREVENTIVE HEALTH SERVICES: *"Preventive Health Services"* are services as defined under federal law (PPACA) and related regulations as including (1) evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved, (2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control with respect to the individual involved, (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, and (4) with respect to women, to the extent not described in above, preventive care and screenings include those provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration and developed in accordance with 45 CFR 147.130(a)(1)(iv).

PRIMARY CARE PHYSICIAN: *"Primary Care Physician"* means an Individual's main health care Provider in non-emergent situations. The Primary Care Physician (PCP) provides care You need to be healthy. The PCP may make referrals to Specialists. The PCP may be:

- FAMILY PRACTITIONER, who is either an MD or DO, and has completed a family practice residency, and is either board-certified or board-eligible.
- PEDIATRICIAN, who is either an MD or DO, and has completed a family practice residency, and is either board-certified or board-eligible.
- GERIATRICIAN, who is either an MD or DO, and has completed a residency in either family medicine or internal medicine, and is board-certified in this specialty.
- INTERNIST, who is either an MD or DO, and has completed a residency in internal medicine, and is either board-certified or board-eligible.

Primary Care Physicians:

- Provide primary preventive care;
- Diagnose and treat common medical conditions;
- May make referrals to medical Specialists when indicated;
- Assess the urgency of any medical condition and direct the patient to the appropriate point within the continuum of care.

PRIMARY PLAN: Under the Coordination of Benefits rules of this 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" means the process of confirming coverage and securing a prior authorization/approval for a proposed treatment, service, or length of stay that requires Prior Authorization as set forth in this Plan. See also "Precertification".

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

PSYCHIATRIC CARE: *"Psychiatric Care"* (Psychoanalytic Care) means treatment for a Mental and/or Nervous Disorder, alcoholism or drug abuse.

PSYCHIATRIC TREATMENT FACILITY: *"Psychiatric Treatment Facility"* means an administratively distinct governmental, public, private or independent unit or part of such unit that provides Outpatient mental health services and which provides for a Psychiatrist who assumes the overall responsibility for coordinating the care of all patients.

PSYCHOLOGIST: *"Psychologist"* means an individual holding the degree of Ph.D. and acting within the scope of his license.

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.

RESIDENTIAL TREATMENT FACILITY: *"Residential Treatment Facility"* means an institution which complies with licensing and other legal requirements in the jurisdiction where it is located; is engaged mainly in providing services for the treatment of Mental Health and/or Substance Abuse in return for compensation; the services include Room and Board and 24-hour-a-day nursing services; the services are supervised by a Physician or by a Registered Nurse. If the services are not supervised by a Physician, the Facility must have a Physician available on a prearranged basis; it maintains daily clinical records; and it must not be mainly a place of rest, a place for the aged, or a nursing or convalescent home.

ROOM AND BOARD: *"Room and Board"* means all charges by whatever name called, which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

SECONDARY PLAN: Under the Coordination of Benefits rules of this 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.

SEMI-PRIVATE: *"Semi-Private"* means a class of accommodations in a Hospital or Skilled Nursing Facility in which at least two patients' beds are available per room.

SITE OF CARE: Choice for physical location of approved services. Sites of Care can include, but are not limited to, hospital inpatient, hospital outpatient, community office, free standing diagnostic testing centers, ambulatory infusion suite, specialty pharmacy, or home-based setting. Site of Care is a component of Medical Necessity review to determine the level of benefit for reimbursement based on the appropriate location for specific services to be provided.

SKILLED NURSING FACILITY: *"Skilled Nursing Facility"* means a licensed institution, or distinct part of one, operated according to law and one, which meets *ALL* of the following conditions:

1. It provides Inpatient care for persons convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) and physical restoration service to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities; and

2. Its services are provided for compensation from its patients and under the full time supervision of a Physician or Registered Nurse;

3. It provides twenty-four (24) hour per day nursing service by licensed Nurses, under the direction of a Full-Time Registered Nurse;

4. It maintains a complete original record on each patient;

5. It has an effective organization review plan;

6. It is not other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardation, custodial, or educational care, or care of Mental and/or Nervous Disorders;

7. It is approved and licensed by Medicare.

This term shall also apply to expenses incurred in an institution referring to itself as a convalescent nursing facility, extended care facility, convalescent nursing home, or any other similar name.

SPECIALISTS: *"Specialists" are* either an MD or DO and have completed advanced education and clinical training in a specific area of medicine. They are either board-certified or board-eligible. They provide specialized care for a specific disease or part of the body.

SPECIALTY MEDICATION: *"Specialty Medication"* means a Medication or treatment for chronic Illnesses that require special handling techniques, careful administration, and a unique ordering process.

STABILIZE: *"Stabilize"*, with respect to an Emergency Medical Condition, means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the Individual from a facility, or, with respect to an Emergency Medical Condition involving a pregnant woman having contractions to deliver.

SUBSTANCE ABUSE: *"Substance Abuse"* means a Substance Abuse disorder as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders and/or the most current version of the International Classification of Diseases.

SURGERY: *"Surgery"* means any cutting procedure or procedure which involves the insertion of an instrument into an internal organ (such as cystoscopy and colonoscopy) or "underwater shock wave treatment".

TERMINAL ILLNESS: *"Terminal Illness"* means a disease or sickness where the Covered Person is expected to live six (6) months or less. This must be certified by the attending Physician.

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, and 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 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 specialty recognize the treatment or service to be safe and effective in treating the medical condition for which it is intended.

URGENT CARE: *"Urgent Care"* is any claim for medical care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations:

1. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or,

2. In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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 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.

UTILIZATION MANAGEMENT: *"Utilization Management"* means the procedures a Covered Person must follow to obtain approval of Covered Services prior to or during the course of care including but not limited to Precertification, referral procedures, utilization review, concurrent review, second surgical opinions, case management, Outpatient Surgery review, and center of excellence care.

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.

WELL BABY/CHILD CARE: *"Well Baby/Child Care"* means medical treatment, services or supplies rendered to a newborn or child up to the age limitation specified in the Schedule of Benefits solely for the purpose of health maintenance and not for the treatment of an Illness or Injury (including Physician office visits and standard and appropriate periodic checkups and immunizations).

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

GENERAL PROVISIONS

DISCLAIMER: REFERENCES TO ERISA SHALL NOT BE APPLICABLE TO SELF-FUNDED PUBLIC EMPLOYERS.

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.