Health Care Benefit Chart

Issued & Underwritten by

McKinley Life Insurance Company

Open Enrollment
Standard Plan
January 1, 2010

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

BENEFITS CHART – TABLE OF CONTENTS

I. Description of Requirements and Terms under the Policy between You and McKinley Life Insurance Company

Your Eligibility Requirements .... A
Your Coverage Ends .... B
Your Dependent's Coverage Ends C
Maximum Time to Submit a Claim C

II. Benefit Levels Under the Policy Between You and McKinley Life Insurance Company

Co-pay .... D
Annual Deductible .... D
Co-insurance (Out-of-Pocket Expense) .... D
Annual Out-of-Pocket Maximum .... D
Lifetime Maximum .... D

III. Covered services under your policy

A. Inpatient, Outpatient, and Physician Office Care

Allergy Extract .... E
Allergy Injections .... E
Allergy Testing .... E
Anesthesia .... E
Bio-Feedback .... F
Cardiac Rehabilitation I,II,III .... G
Chemo/Radiation Therapy .... G
Dialysis .... H
Injections (Medical) I
Inpatient Hospital Admission .... J
Inpatient Hospital Physician .... J
Laboratory/X-Ray/Diagnostic .... J
Mammography (Medical Diagnosis) .... K
Maternity L
Occupational Therapy L
Office Visit .... M
Organ Donor Coverage .... M
Organ Transplant Coverage .... N
Physical Therapy .... N
Pre-Admission Testing .... O
Prescription Drugs .... O
Rehabilitation Services .... O
Respiratory Therapy .... P
Speech Therapy .... Q
Surgery .... Q

B. Emergency and Urgent Care .... T
Emergency Care .... T
Urgent Care .... T

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C. Mental Health and Alcohol/Substance Abuse V

D. Other Services
Abortion .... Y
Ambulance .... Y
Blood Replacement Programs .... Y
Breast Prosthesis/Bra .... Y
Durable Medical Equipment .... Z
Hepatitis Vaccination High Risk .... Z
Home Health Care .... Z
Hospice Care .... Z
Skilled Nursing .... AA

E. Educational Training .... BB
Diabetic Education .... BB
Educational Training .... BB

F. Preventive Care CC
Gynecological Pap Test CC
Mammography (Routine) CC
Well Child Care CC
Breast Reconstructive Surgery after Mastectomy .... DD
Immunizations Beyond Well Child .... DD
Ultrasound (Routine Maternity) .... DD

G. Affiliate Providers .... EE
Chiropractic Coverage .... EE
Podiatry Coverage .... FF

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Benefits* Chart

This Benefits Chart (also called "Schedule of Benefits") is part of Your Policy. It explains Your specific Coverage and Benefits, including what You need to pay, what We will pay, and the Limitations and Exclusions in the Policy.

If You have questions, please call AultCare's Service Center at (330) 363-6360 or 1-800-344-8858. You also can email Us at www.aultcare.com.

I. DESCRIPTION OF REQUIREMENTS AND TERMS UNDER THE POLICY BETWEEN YOU AND MCKINLEY LIFE INSURANCE COMPANY

Your Eligibility Requirements

- You are Eligible if:

  1. You are a Federally Eligible individual; or

  2. You have lost coverage under a prior group health insurance policy with McKinley and:
     a. You were continuously Covered under the prior group health insurance policy for at least one year.

     b. Your termination of Coverage was not based on non-payment of Premiums.

     c. You are not, or are not eligible to be, Covered for Benefits that are at least comparable to the prior group health insurance policy with McKinley under:

        (i) Medicare.

        (ii) Any state or federal law.

        (iii) Any policy or insurance or hospitalization plan providing comparable Benefits.

- Your Spouse may be Eligible as a Dependent if You are legally married under Ohio law

- Your Children may be Eligible as Dependents if the Child is:

  1. Your natural-born or legally Adopted Child (See Section 35) who is under 19 years old.

  2. Your Stepchild (See Section 35) who is under the age of 19 and is living with You. You must give Us a time-stamped court order.

  3. Named in a Qualified Medical Child Support Order (See Section 35) and is otherwise Eligible for Coverage. You must give Us a time-stamped court order.

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4. A Child for whom the court has named You Guardian (See Section 35). You must give Us a time-stamped court order.

5. Not married.

6. Not in the armed forces of any country.

7. Dependent on You for principal support according to IRS Dependency Guidelines (See Section 35).

- A Dependent Child will remain eligible until the end of the month in which the Child reaches age 19 unless the Child is a Full-time Student or has a physical or mental handicap, providing proof of disability is given before the limiting age.

- Full-time Student means the Child is under the age of 24 at the end of the calendar year and is taking the minimum number of hours per semester at a college, university, or trade school. The Student also must be unmarried and must depend on You for main support according to IRS Dependent guidelines. In the event an otherwise eligible Full-Time Student must take a Medically Necessary leave of absence or changes to part-time status due to a Medically Necessary leave of absence, coverage will continue for 12 months provided the Employee remains on the Plan.

Your Coverage Ends

Your Coverage will end on the earliest of the following:

1. The date We determine that You have committed fraud or intentional material misrepresentation against Us;

2. For nonpayment of Premium, the last day of the period of time for which You paid Premium, subject to the grace period; or

3. When We cease to offer a type of policy or cease to do business in the individual medical insurance market, as applicable and as allowed by state requirements.

   (a) If We decide to discontinue offering this type of policy:

      i. You will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such Coverage; and

      ii. You will be given the option to purchase any other similar policy providing medical benefits that We offer at such time.

   (b) If We decide to cease doing individual medical insurance business in this state, We will provide You and the Commissioner of Insurance with notice of such discontinuation at least 180 days prior to the discontinuation of such Coverage.

4. The date You no longer reside in the State of Ohio.

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Your Dependent's Coverage Ends:

Dependent Coverage will end at the earliest of:

1. The date Your Coverage ends;
2. The last day of the Coverage Month during which the Person ceases to be a Dependent;
3. The end of the period for which the last Premium has been paid for the Dependent;

Maximum Time to Submit a Claim

The maximum time in which to submit a claim in order for it to be processed is 15 months.

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II. BENEFIT LEVELS UNDER THE POLICY BETWEEN YOU AND MCKINLEY LIFE INSURANCE COMPANY

The level of Benefits* You receive under Your Policy, and the amount You must pay Out-of-Pocket, depend on whether You receive medical services from Network Providers. You usually will need to pay more Out-of-Pocket if You go to a Non-Network Provider.

Policy Provision	Network Provider	Non-Network Provider
Co-pay: The set dollar amount You pay Out-of-Pocket for each Doctor Office Visit. The co-pay does not count against Your Annual Deductible.	See Covered Benefit for applicable Co-pay	See Covered Benefit for applicable Co-pay
Annual Deductible: The minimum amount You must pay Out-of-Pocket each year before Benefits are paid under the Policy.	$750 per individual	$750 per individual
Co-insurance (Out-of-Pocket Expense): This is the percentage of medical expense You share with the Policy after You meet Your **Annual Deductible** and **Co-pay**.	Your share of the charge: 20%	Your share of UCR: 40% plus any charges in excess of UCR
Annual Out-of-Pocket Maximum: This is the total amount You pay Out-of-Pocket in one Year before the Policy pays 100% of Your medical expenses. It includes Your Deductible and Coinsurance. It does not include Co-payments	$3,000 per individual Once You have met this maximum, the Policy begins to pay covered medical expenses at 100% except for mental health, alcohol/substance dependence services, penalties, and non-emergency care which are not included in the 100% reimbursement provision.	$5,000 per individual Once You have met this maximum, the Policy begins to pay covered medical expenses at 100% except for mental health, alcohol/substance dependence services, penalties, and non-emergency care which are not included in the 100% reimbursement provision.
Lifetime Maximum	$1,000,000 except for annual $550 reinstatement for mental health, alcohol/substance services	$1,000,000 except for annual $550 reinstatement for mental health, alcohol/substance services

Note: If You use Non-Network Providers, only what is paid up to UCR will count toward Your Deductible. Your Deductible and Out-of-Pocket expenses for Non-Network Providers may be separate from Network Providers.

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III. COVERED BENEFITS (SERVICES) UNDER YOUR POLICY*

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Allergy Extract	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Allergy Injections	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Allergy Testing	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Anesthesia In Office	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Anesthesia Outpatient	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Anesthesia Inpatient	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Bio-Feedback In Office	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Bio-Feedback Outpatient	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Bio-Feedback **Inpatient**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Cardiac Rehabilitation I & II **Outpatient** **Cardiac Rehab III not covered**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Cardiac Rehabilitation I & II **Inpatient** **Cardiac Rehab III not covered**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Chemo/Radiation Therapy **In Office**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Chemo/Radiation Therapy Outpatient	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Chemo/Radiation Therapy Inpatient	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Dialysis In Office	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Dialysis Outpatient	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Dialysis **Inpatient**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Injections (Medical) **In Office**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Injections (Medical) **Outpatient**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Injections (Medical) **Inpatient**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Inpatient Hospital Admission (Semi-Private room) **Inpatient Hospital stays in the Intensive Care Unit will be paid at three times the average Semi-Private room rate.**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Inpatient Hospital Physician	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Laboratory/X-Ray/Diagnostic In Office	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Laboratory/X-Ray/Diagnostic Outpatient	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Laboratory/X-Ray/Diagnostic Inpatient	<u>You Must Pay:</u> Deductible $750 Coinsurance 20% After Annual Max $0 <u>We Will Pay:</u> Coinsurance 80% After Annual Max 100%	<u>You Must Pay:</u> Deductible $750 Coinsurance 40%UCR After Annual Max $0 <u>We Will Pay:</u> Coinsurance 60% After Annual Max 100%
Mammography (Medical Diagnosis) In Office	<u>You Must Pay:</u> Deductible $750 Coinsurance 20% After Annual Max $0 <u>We Will Pay:</u> Coinsurance 80% After Annual Max 100%	<u>You Must Pay:</u> Deductible $750 Coinsurance 40%UCR After Annual Max $0 <u>We Will Pay:</u> Coinsurance 60% After Annual Max 100%
Mammography (Medical Diagnosis) Outpatient	<u>You Must Pay:</u> Deductible $750 Coinsurance 20% After Annual Max $0 <u>We Will Pay:</u> Coinsurance 80% After Annual Max 100%	<u>You Must Pay:</u> Deductible $750 Coinsurance 40%UCR After Annual Max $0 <u>We Will Pay:</u> Coinsurance 60% After Annual Max 100%
Mammography (Medical Diagnosis) Inpatient	<u>You Must Pay:</u> Deductible $750 Coinsurance 20% After Annual Max $0 <u>We Will Pay:</u> Coinsurance 80% After Annual Max 100%	<u>You Must Pay:</u> Deductible $750 Coinsurance 40%UCR After Annual Max $0 <u>We Will Pay:</u> Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Maternity (Plan Approval Required) Benefit Limitation: $3,000 per occurrence	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Maternity Dependent Care Benefit Limitation: $3,000 per occurrence	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Occupational Therapy In Office Illness or Injury related	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Occupational Therapy Outpatient Illness or Injury Related	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Occupational Therapy Inpatient **Illness or Injury Related**	<u>You Must Pay:</u> Deductible $750 Coinsurance 20% After Annual Max $0 <u>We Will Pay:</u> Coinsurance 80% After Annual Max 100%	<u>You Must Pay:</u> Deductible $750 Coinsurance 40%UCR After Annual Max $0 <u>We Will Pay:</u> Coinsurance 60% After Annual Max 100%
Office Visit Illness	<u>You Must Pay:</u> Deductible $750 Coinsurance 20% After Annual Max $0 <u>We Will Pay:</u> Coinsurance 80% After Annual Max 100%	<u>You Must Pay:</u> Deductible $750 Coinsurance 40%UCR After Annual Max $0 <u>We Will Pay:</u> Coinsurance 60% After Annual Max 100%
Office Visit Injury	<u>You Must Pay:</u> Deductible $750 Coinsurance 20% After Annual Max $0 <u>We Will Pay:</u> Coinsurance 80% After Annual Max 100%	<u>You Must Pay:</u> Deductible $750 Coinsurance 40%UCR After Annual Max $0 <u>We Will Pay:</u> Coinsurance 60% After Annual Max 100%
Organ Donor Coverage **Plan Approval Required** **Lifetime Maximum: $100,000**	<u>You Must Pay:</u> Deductible $750 Coinsurance 20% After Annual Max $0 <u>We Will Pay:</u> Coinsurance 80% After Annual Max 100%	<u>You Must Pay:</u> Deductible $750 Coinsurance 40%UCR After Annual Max $0 <u>We Will Pay:</u> Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Organ Transplant Coverage Plan Approval Required Lifetime Maximum: $100,000	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Physical Therapy In Office Illness or Injury Related Annual Maximum: 20 visits per Calendar Year Eligible Charge: $40 per visit; additional charges member's responsibility	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60%
Physical Therapy Outpatient Illness or Injury Related Annual Maximum: 20 visits per Calendar Year Eligible Charge: $40 per visit; additional charges member's responsibility	You Must Pay: Deductible $750 Coinsurance 20% Coinsurance 0% We Will Pay: Coinsurance 80%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% UCR
Physical Therapy Inpatient Illness or Injury Related	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Pre-Admission Testing	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Prescription Drugs Annual Maximum: $2,500 per Calendar Year	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Rehabilitation Services In Office Illness or Injury Related	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Rehabilitation Services Outpatient Illness or Injury Related	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Rehabilitation Services Inpatient **Illness or Injury Related**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Respiratory Therapy In Office	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Respiratory Therapy Outpatient	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Respiratory Therapy Inpatient	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Speech Therapy **In Office** **Illness or Injury Related**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Speech Therapy **Outpatient** **Illness or Injury Related**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Speech Therapy **Inpatient** **Illness or Injury Related**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Surgery **In Office**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Surgery **Outpatient (Sameday)**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Surgery **Inpatient**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Surgery **Assistant Surgeon** **Outpatient** Benefit Limitation: 20% of all Eligible Expenses made by the Surgeon performing the procedure. Assistant Surgeon must be Medically Necessary to assist in the performance of the Surgery.	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Surgery **Assistant Surgeon** **Inpatient** Benefit Limitation: 20% of all Eligible Expenses made by the Surgeon performing the procedure. Assistant Surgeon must be Medically Necessary to assist in the performance of the Surgery.	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

Inpatient, Outpatient, and Physician Office Care	Network Provider	Non-Network Provider
Surgery Cosmetic/Reconstructive Illness or Injury Related	<u>You Must Pay:</u> Deductible $750 Coinsurance 20% After Annual Max $0 <u>We Will Pay:</u> Coinsurance 80% After Annual Max 100%	<u>You Must Pay:</u> Deductible $750 Coinsurance 40%UCR After Annual Max $0 <u>We Will Pay:</u> Coinsurance 60% After Annual Max 100%
Surgery Second Surgical Opinion Required for Septo, Rhino, Tenotomy, Recon-cosmetic, veins	<u>You Must Pay:</u> Deductible $750 Coinsurance 20% After Annual Max $0 <u>We Will Pay:</u> Coinsurance 80% After Annual Max 100%	<u>You Must Pay:</u> Deductible $750 Coinsurance 40%UCR After Annual Max $0 <u>We Will Pay:</u> Coinsurance 60% After Annual Max 100%

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

Emergency and Urgent Care	Network Provider	Non-Network Provider
Emergency Care Approved Emergency (See Definition of Emergency Services) Co-pay is waived if admitted to Hospital This co-pay is in addition to and will not be counted toward the Calendar Year Deductible	You Must Pay: Deductible $750 Co-pay $75 After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Co-pay $75 After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Non- Emergency (See Definition of Emergency Services)	You Must Pay: Deductible $750 Coinsurance 20% We Will Pay: Coinsurance 80%	You Must Pay: Deductible $750 Coinsurance 40%UCR We Will Pay: Coinsurance 60%
Emergency Care Out of Service Area Co-pay is waived if admitted to Hospital This co-pay is in addition to and will not be counted toward the Calendar Year Deductible	You Must Pay: Deductible $750 Co-pay $75 After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Co-pay $75 After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Urgent Care	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Emergency and Urgent Care	Network Provider	Non-Network Provider
Urgent Care **Non-Approved**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Mental Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
Mental Health Outpatient Annual Maximum: $550 per calendar year for Outpatient Mental Health treatment (excluding Biologically Based Mental Health treatment) Lifetime Maximum: $10,000 for Inpatient and Outpatient Mental Health and Alcohol/Substance Abuse treatment (excluding Biologically Based Mental Health treatment) Eligible Charge: $50 per visit; additional charges member's responsibility	You Must Pay: Deductible $750 Coinsurance 20% We Will Pay: Coinsurance 80%	You Must Pay: Deductible $750 Coinsurance 40% We Will Pay: Coinsurance 60%
Mental Health Inpatient Annual Maximum: $2,000 per calendar year for Inpatient Mental Health treatment (excluding Biologically Based Mental Health treatment) Lifetime Maximum: $10,000 for Inpatient and Outpatient Mental Health and Alcohol/Substance Abuse treatment (excluding Biologically Based Mental Health treatment)	You Must Pay: Deductible $750 Coinsurance 20% We Will Pay: Coinsurance 80%	You Must Pay: Deductible $750 Coinsurance 40% We Will Pay: Coinsurance 60%
Mental Health Outpatient Treatment Programs Annual Maximum: $550 per calendar year for Outpatient Mental Health treatment (excluding Biologically Based Mental Health treatment) Lifetime Maximum: $10,000 for Inpatient and Outpatient Mental Health and Alcohol/Substance Abuse treatment (excluding Biologically Based Mental Health treatment) Annual $550 reinstatement provision beyond the Lifetime Maximum	You Must Pay: Deductible $750 Coinsurance 20% We Will Pay: Coinsurance 80%	You Must Pay: Deductible $750 Coinsurance 40% We Will Pay: Coinsurance 60%

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Mental Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
Biologically Based Mental Illness Outpatient	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Biologically Based Mental Illness Inpatient	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Biologically Based Mental Illness Outpatient Treatment Programs	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

Mental Health and Alcohol/Substance Abuse	Network Provider	Non-Network Provider
Alcohol/Substance Abuse Outpatient Annual Maximum: $550 per calendar year for Outpatient Alcohol/Substance Abuse treatment Lifetime Maximum=$10,000 for Inpatient and Outpatient Mental Health and Alcohol/Substance Abuse treatment (excluding Biologically Based Mental Health treatment) Eligible Charge: $50 per visit; additional charges member's responsibility	You Must Pay: Deductible $750 Coinsurance 20% We Will Pay: Coinsurance 80%	You Must Pay: Deductible $750 Coinsurance 40%UCR We Will Pay: Coinsurance 60%
Alcohol/Substance Abuse Inpatient Annual Maximum: $2,000 per calendar year for Inpatient Alcohol/Substance Abuse treatment Lifetime Maximum:$10,000 for Inpatient and Outpatient Mental Health and Alcohol/Substance Abuse treatment (excluding Biologically Based Mental Health treatment)	You Must Pay: Deductible $750 Coinsurance 20% We Will Pay: Coinsurance 80%	You Must Pay: Deductible $750 Coinsurance 40%UCR We Will Pay: Coinsurance 60%
Alcohol/Substance Abuse Outpatient Treatment Programs Annual Maximum: $550 per calendar year for Outpatient Alcohol/Substance Abuse treatment Lifetime Maximum: $10,000 for Inpatient and Outpatient Mental Health and Alcohol/Substance Abuse treatment (excluding Biologically Based Mental Health treatment)	You Must Pay: Deductible $750 Coinsurance 20% We Will Pay: Coinsurance 80%	You Must Pay: Deductible $750 Coinsurance 40%UCR We Will Pay: Coinsurance 60%

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Other Services	Network Provider	Non-Network Provider
Abortion Therapeutic Elective Abortions are not covered	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Ambulance	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 20%UCR After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%
Blood Replacement Programs (Blood not replaced)	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Breast Prosthesis/Bra Initial Replacement prosthesis is covered if Medically Necessary and in connection with a Mastectomy Replacement bra is covered if Medically Necessary and in connection with a Mastectomy	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Other Services	Network Provider	Non-Network Provider
Durable Medical Equipment **Purchase or rental of Durable Medical Equipment covered (whichever costs less) for temporary use, not to exceed six months**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Hepatitis Vaccination **High Risk**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Home Health Care **Annual Maximum: $5,000 per calendar year for Home Health Care, Hospice Care and Skilled Nursing Facilities services combined.**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Hospice Care **Annual Maximum: $5,000 per calendar year for Home Health Care, Hospice Care and Skilled Nursing Facilities services combined.**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Other Services	Network Provider	Non-Network Provider
Skilled Nursing **(Plan Approval Required)** **Annual Maximum: $5,000 per calendar year for Home Health Care, Hospice Care and Skilled Nursing Facilities services combined.**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Educational Training	Network Provider	Non-Network Provider
Diabetic Education **Outpatient** **(Plan Approval Required)**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Diabetic Education **Inpatient** **(Plan Approval Required)**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Educational Training **Outpatient** **(Plan Approval Required)** **Medically Necessary**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Educational Training **Inpatient** **(Plan Approval Required)** **Medically Necessary**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Preventive Care	Network Provider	Non-Network Provider
Gynecological Pap Test (Routine) Annual Maximum: One per Calendar Year	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Mammography (Routine Screening) The total benefit for a screening mammography shall not exceed 130% of the Reimbursed Medicare Amount. This constitutes payment in full. Benefit Limitation: Age 35-39: One mammogram Age 40-49: One mammogram every two years or annually if woman has risk factors for breast cancer Age 50-64: One mammogram per Calendar Year	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100% We will pay Benefit Costs up to 130% of the Medicare reimbursement rate in Ohio for screening mammography	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100% We will pay Benefit Costs up to 130% of the Medicare reimbursement rate in Ohio for screening mammography
Well Child Care (Hearing Screening included for age 0-12 months, benefit not to exceed $75) Annual Maximum: Birth to age 1- $500 per Calendar Year Age 1-8 – $150 per Calendar Year	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Preventive Care	Network Provider	Non-Network Provider
Breast Reconstructive Surgery after Mastectomy	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Immunizations Beyond Well Child Care	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Ultrasound (Routine Maternity) **Subject to Maternity Benefit Limitation**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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Affiliate Providers	Network Provider	Non-Network Provider
Chiropractic Coverage Office Visit **Annual Maximum: 10 visits per Calendar Year** **Eligible Charge: $25 per visit; additional charges member's responsibility**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 100%
Chiropractic Coverage Other Services **Annual Maximum: 10 visits per Calendar Year** **Eligible Charge: $25 per visit; additional charges member's responsibility**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 100%
Chiropractic Coverage Diagnostic Testing **Annual Maximum: 10 visits per Calendar Year** **Eligible Charge: $25 per visit; additional charges member's responsibility**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 100%

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Affiliate Providers	Network Provider	Non-Network Provider
Podiatry Coverage **Office Visit** **Illness or Injury Related**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Podiatry Coverage **Diagnostic/Testing** **Illness or Injury Related**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Podiatry Coverage **Surgery** **Illness or Injury Related**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%
Podiatry Coverage **Other Services** **Illness or Injury Related**	You Must Pay: Deductible $750 Coinsurance 20% After Annual Max $0 We Will Pay: Coinsurance 80% After Annual Max 100%	You Must Pay: Deductible $750 Coinsurance 40%UCR After Annual Max $0 We Will Pay: Coinsurance 60% After Annual Max 100%

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McKinley Life Insurance Company
Canton, Ohio

Standard Policy and Benefits

This Policy explains the basics of Your Health Care Coverage, Benefits and duties. Your Benefits Chart, which is a part of this Policy, gives the details of Your Coverage, including exceptions to the general Exclusions, as well as the rules You must follow, and how much You may need to pay. Keep them in a safe place. Check both this Policy and Your Benefits Chart when You have questions.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Please call (330) 363-6360 or toll-free at 1-800-344-8858 to talk to Customer Service, or email Us at www.aultcare.com. You also may write Us at:

AultCare Service Center
P.O. Box 6910
Canton, OH 44706

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

TABLE OF CONTENTS

Important Telephone Numbers and Addresses....3

Exclusions under the Policy....4

Section 1 – Basic Information at a Glance....6
Section 2 – Fraud Warning....8
Section 3 – Your Duties and Rights....8
Section 4 – Let Us Know When Your Records Need To Be Updated....9
Section 5 – Eligibility for Coverage and Benefits....10
Section 6 – Special Circumstances for a Child Who is a Full-Time Student....11
Section 7 – Special Circumstances for a Child With a Disability....12
Section 8 – Enrollment....12
Section 9 – Coverage....13
Section 10 – Coverage for Enrollees and Dependents....14
Section 11 – Converting to An Individual Healthcare Coverage Contract....16
Section 12 – Guaranteed Renewability....17
Section 13 – Using Network Providers....17
Section 14 – Covered Services (Benefits)....18
Section 15 – Covered Outpatient Services....19
Section 16 – Covered Inpatient Hospital Services....20
Section 17 – Emergency and Urgent Care Services....22
Section 18 – Other Covered Services....23
Section 19 – Managed Prescription Drug Program....31
Section 20 – Exclusions....31
Section 21 – Pre-Approval, Concurrent Review, Second Opinions....32
Section 22 – Using Your AultCare ID Card....33
Section 23 – Your Responsibility for Co-payments, Deductible, Co-Insurance....34
Section 24 – Usual, Reasonable, and Customary ("UCR")....34
Section 25 – Filing Your Claim....35
Section 26 – Your HIPAA Privacy Rights....37
Section 27 – Benefit Determination....37
Section 28 – Coordination of this Contract's Benefits with Other Benefits ("COB")....36
Section 29 – Explanation of Benefits ("EOB")....42
Section 30 – Subrogation....43
Section 31 – Determination Time Frames....45
Section 32 – Questions, Complaints, Review and Appeals....46
Section 33 – External Review....49
Section 34 – Expedited Review....50
Section 35 – Definitions and Index....51
General Provisions....69

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

Important Telephone Numbers and Addresses

If You have a question, problem, or complaint, please call our Service Center. Our hours are 7:30 a.m. to 5:00 p.m., Monday through Friday.

If You live in Stark County, call (330) 363-6360. You also may call Our toll-free number 1-800-344-8858.

You can email us at www.aultcare.com. Click on "Contact Us." We will direct Your question to the proper person to answer. We will attempt to respond promptly, but that may not be the same day in which You emailed Us. If You have a question that needs immediate attention, please call Us.

You can fax us at (330)-363-7746. You can write Us at:

AultCare Service Center
P.O. Box 6910
Canton, Ohio 44706

If You write, please list Your Policy number and AultCare ID Number in Your letter. This information is on Your AultCare ID Card. If You call, please have Your current AultCare ID Card in front of You.

The address for the Ohio Department of Insurance is:

Ohio Department of Insurance
Consumer Services Division
50 W. Town Street
Third Floor – Suite 300
Columbus, OH 43215

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

EXCLUSIONS UNDER THE POLICY

No benefits will be paid for:

1. Transportation, except local to or from a Hospital by professional ground ambulance services
2. Normal childbirth, normal pregnancy or routine nursery care (except as provided in the Schedule of Benefits) elective cesarean section or voluntarily induced abortion.
3. Fertility or infertility studies, diagnostic testing advice, consultation, examination, medication, or for any treatment related to or connected in any way with the restoration or enhancement of fertility or the inability to conceive or conception by artificial means, including, but not limited to, in-vitro fertilization or embryo transfer.
4. Replacement of artificial limbs and artificial eyes.
5. Blood or blood plasma which has been replaced.
6. Donation of any body organ by an insured person.
7. Services performed by a person who ordinarily resides in the insured person's home or is a close relative of the insured person or by the insured person's employer or partner.
8. Cosmetic surgery, except as stated in the plan or required to restore a part of the body that has been altered as a result of an accidental bodily injury or illness.
9. Custodial care.
10. Services or treatments not prescribed by a doctor or for services or treatments not shown as covered.
11. An illness arising out of, or in the course of, employment for wages or profit.
12. Expenses incurred after the insurance terminates.
13. Experimental or investigational treatments or services.
14. Eye Surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including, but not limited to radial keratotomy; or for eye refractions, eye glasses or contact lens including fitting or examinations.
15. Treatment, services or supplies furnished by a department or agency of the United States Government. This exclusion will not apply to a non-service connected illness of a veteran of the United States armed forces who does not have service-connected illness.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

16. Services and supplies eligible for payment by a government or charitable programs, except as required by law.

17. Hearing aids, including fitting and examinations.

18. Non-medically necessary care or treatment of an illness.

19. Which would not be made if no insurance existed.

20. Recreational or educational therapy or vocational rehabilitation.

21. Speech or occupational therapy and related diagnostic testing if the therapy or testing is in connection within or related in any way to the treatment of a learning disability, speech impediment, or developmental delay even though therapy is recommended dud to organic dysfunction, including, but not limited to, congenital deformity or birth trauma, except as allowed under covered charges.

22. For which the insured is not legally obliged to pay.

23. Treatment or services which are not generally accepted medical practices in the United States for a given illness.

24. Treatment of obesity, morbid obesity or for weight reduction purposes.

25. Illnesses that results from participation in any assault, unlawful act. Strike, civil disorder or riot.

26. The treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and the implantation of a penile prosthesis

27. Routine physical, gynecologic, or premarital examination except as may be covered under the child wellness benefit. Mammograms and pap smears are covered.

28. A private room in excess of the average semi-private room and board rate.

29. A pre-existing condition. This exclusion relates to conditions treated during the six months immediately preceding the effective date of this coverage. Benefits will be paid for such charges incurred after the end of the period of twelve (12) consecutive months while insured under the policy. This exclusion does not apply to federally eligible individuals.

30. Amounts in excess of reasonable and customary charges.

31. Services or supplies prohibited by law.

32. Sex changes.

33. Sterilization and reversal of sterilization.

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34. Charges resulting from any suicide, attempted suicide or intentionally self-inflicted injury or sickness while sane or insane unless such act is the result of an underlying medical condition.

35. Examination, treatment or surgery of the teeth, gums or direct supporting structure, except for repair of injury to sound natural teeth, (including their replacement) as a result of an accidental bodily injury. Treatment must be given within ninety (90) days of the date of the accident to be covered.

36. Illness caused by any act of war, whether or not declared.

37. Surrogate pregnancy.

38. Surgery of the jaw or for any treatment of temporomandibular joint (TMJ) disorder. Treatment of jaw fractures and removal of tumors of the jaw will not be subject to this exclusion.

39. Treatment of complications arising from or connected in any way with a surgical or medical treatment or procedure that is not a covered expense under the terms of the policy, whether or not the insured person was insured under the policy at the time the non-covered treatment or procedure was performed.

40. Foot care due to:
    a. treatment of weak, strained or flat feet or instability or imbalance of the foot.
    b. Treatment of corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illnesses of similar medical seriousness

41. For contraceptives, infertility drugs and growth hormones.

Section 1 – Basic Information at a Glance

Thank You for choosing McKinley Life Insurance Company.

A. <u>Who We Are</u>

Your Coverage and Benefits are through McKinley Life Insurance Company. McKinley Life Insurance Company has a contract with its affiliate, AultCare Corporation, to provide services. Your ID Card will have McKinley Life Insurance Company's name on it. It also may have AultCare's name on it.

We may use "McKinley," "AultCare," or "We," or "Us" to mean McKinley Life Insurance Company.

We will use "You" to mean You and Your Eligible Dependents who are Covered under this Policy.

B. Using this Policy and Benefits Chart

This Policy explains the basics of Your Coverage and Benefits. Your Benefits Chart, which is a part of this Policy, gives the details of Your Coverage, including exceptions to the general Exclusions, as well as the rules You must follow, and how much You may need to pay. Check both this Policy and Your Benefits Chart when You have questions.

C. Independent Medical Decisions

We do not employ Network Providers. We do not practice medicine. Your doctor is an independent practitioner. AultCare does not tell Your doctor how to practice medicine. We do not forbid Network Providers from talking to You about treatment options, even if these options are not Covered. Your doctor is solely responsible for the medical care he or she provides. Hospitals and other providers are solely responsible for the Services they provide.

We are not liable if doctors, hospitals, pharmacies or others make mistakes about Your care. This applies to Network Providers and Non-Network Providers. You must not file a lawsuit against McKinley or AultCare for the negligence of Providers.

D. Claim Forms

You do not need to send in Claim forms when You go to a Network Provider. You may need to send in forms if You go to a Non-Network Provider.

E. Case Management

Case Management coordinates Your inpatient and outpatient care with Providers. Case Management will review Your plan of treatment, expected length of hospital stay (if You are admitted to a hospital), and other details of Your care to make sure You receive appropriate Benefits. Sometimes, a Case Manager may call to help You.

F. Utilization Management

Certain Services, such as admissions, referrals, Home HealthCare Services, and Durable Medical Equipment need Pre-Approval (**See Section 21 and Section 35**) by the Utilization Management Department (**See Section 35**). We will use "UM" throughout this Certificate to mean Utilization Management. UM will promptly notify You of its decisions in writing.

If You are in the middle of ongoing healthcare, such as a Hospital stay, and a decision is made not to Cover all or part of Your stay, Coverage for Your healthcare will continue until You are notified of the decision. Benefits may stay the same for this period.

In extreme situations or catastrophic illness, You may be able to receive Benefits for Services that are not specifically Covered if they can be offered in a non-Hospital setting. Case Management will decide when this is appropriate.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

In situations where a faster decision is needed because of Your medical condition, UM will be done sooner. We will promptly notify You in writing. If You are unhappy with UM's decision, You can Appeal (**See Section 21**).

G. Definitions

Some terms in this Policy have special meaning. Capitalized terms are defined in Section 35. The Definitions Section also is an Index, which directs You to where those terms are used in this Policy. If You do not know what a term means, call Us at (330) 363-6360 or 1-800-344-8858.

Section 2—Fraud Warning

Any person who intentionally sends in an application or files a Claim containing a false or deceptive statement is guilty of insurance Fraud. If You know of Fraud, or believe Fraud may be occurring, contact our website at **www.aultcare.com**, or call Us at the Fraud hotline **1-800-204-5119, or 330-363-2887,** or write Us at:

AultCare
P.O. Box 6910
Canton, Ohio 44706

Section 3 – Your Duties and Rights

Your health care and Benefits are a shared responsibility. We want You to know Your Duties and Rights. Please read this section carefully. If You have a question, or if You have ideas how We may improve, email Our website at **www.aultcare.com**.

A. You have a Duty to:

1. Bring Your current AultCare ID Card when You go to Your doctor, hospital, or drug store. It contains important information. Having Your card may save time and prevent mistakes.

2. Be a good patient. Tell Your doctor or nurse about Your condition. Describe Your symptoms and how long You have had them. Let Your doctor know what drugs You are taking. Answer all questions fully and truthfully. Your doctor needs this information to help diagnose Your condition and set treatment goals and options.

3. Be a good patient by asking questions if You don't understand something about Your medical condition and treatment options (including drugs).

4. Be a good patient by following Your doctor's advice and instructions. Take drugs as directed. Let Your doctor know if You have a bad reaction, if You don't get better, or if You get worse. Make follow-up appointments.

5. Be a good patient by living a healthy lifestyle. Eat properly. Watch Your weight. Get plenty of rest. Exercise. If you drink, do so moderately. Don't drink and drive. Don't smoke. Use Your seatbelts. Get regular check-ups.

6. Be a good Enrollee by getting all Pre-Approvals and Second Opinions, when needed.

7. Be a good Enrollee by checking Your Benefits Chart, asking Us, or checking Our website **www.aultcare.com** if You have questions about Your Coverage, Benefits, Exclusions, or duties.

B. <u>You have a Right to</u>:

1. Know Your Coverage, Benefits and Services described in this Certificate and Benefit Chart.

2. To see a Directory of doctors, hospitals and other Network Providers. Check Our website at **www.aultcare.com** or call Us at (330) 363-6360 or 1-800-344-8858.

3. Be treated with dignity and respect.

4. A frank discussion with Your doctor about Your medical condition and treatment options, regardless of cost or Coverage. AultCare does not prohibit doctors from discussing all treatment options with You.

5. Privacy of Your health care and Claims information. Your doctors and AultCare will use Your Protected Health Information (**See Section 26 and Section 35**) to pay Claims, as permitted by HIPAA (**See Section 26 and Section 35**) and as described in Your Notice of Privacy Practices. We will not disclose Your Protected Health Information, including Claims information, to persons for reasons other than Treatment, Payment, and Healthcare Operations without Your Authorization, unless the law requires.

6. Ask questions, file Complaints and appeal Denials.

Section 4 – Let Us Know When Your Records Need To Be Updated
Check Your Benefits Chart for Details

A. <u>Keeping Your Records Up-to-Date is IMPORTANT</u>

Having up-to-date records about You and Your Dependents is needed to know what Services are Covered and what Benefits You may receive. Out-dated or incorrect information can cause mistakes, delays or Denial of Coverage.

B. <u>Updating Records</u>

Tell Us within **31** calendar days if there are changes in Your name, address, phone number, marital status, or if there are changes with Your Dependents, such as when You have a Newborn or Adopted Child (**See Section 35**).

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

Each year You need to tell Us about any changes to Your Coverage, including Coverage and Benefits You or Your Dependents may have from other insurance.

C. <u>Using Your Current AultCare ID Card</u>

It is important that You use Your current AultCare ID Card when You go to the hospital, see Your doctor or other Provider, or go to the drug store. Let Your Provider know when You get a new AultCare ID Card or if Your Coverage or Benefits change.

Section 5 – Eligibility for Coverage and Benefits
Check Your Benefits Chart for Details

A. <u>Eligibility</u>

Eligibility means that You and Your Dependents meet the requirements to enroll as a Covered Person under the Policy and receive Coverage and Benefits.

B. <u>Enrollee Eligibility</u>

You are Eligible if:

1. You are a Federally Eligible individual; or

2. You have lost coverage under a prior group health insurance policy with AultCare and:
    a. You were continuously Covered under the prior group health insurance policy for at least one year.

    b. Your termination of Coverage was not based on non-payment of Premiums.

    c. You are not, or are not eligible to be, Covered for Benefits that are at least comparable to the prior group health insurance policy with AultCare under:

        (i) Medicare.

        (ii) Any state or federal law.

        (iii) Any policy or insurance or hospitalization plan providing comparable Benefits.

C. <u>Eligibility of Your Spouse as a Dependent</u>

Your Spouse may be Eligible as a Dependent if You are legally married under Ohio law (**See Section 35**).

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

D. <u>Eligibility of Children as Dependents</u>

Your Children may be Eligible as Dependents if the Child is:

1. Your natural-born or legally Adopted Child (**See Section 35**) who is under **19** years old.

2. Your Stepchild (**See Section 35**) who is under the age of 19 and is living with You. You must give Us a time-stamped court order.

3. Named in a Qualified Medical Child Support Order (**See Section 35**) and is otherwise Eligible for Coverage. You must give Us a time-stamped court order.

4. A Child for whom the court has named You Guardian (**See Section 35**). You must give Us a time-stamped court order.

5. Not married.

6. Not in the armed forces of any country.

7. Dependent on You for principal support according to IRS Dependency Guidelines (**See Section 35**).

E. <u>No Genetic Screening</u>

Eligibility for Coverage is not subject to genetic testing or any results of genetic testing.

F. <u>Tell Us When a Dependent No Longer is Eligible</u>

You must tell Us within **31** calendar days if a Child no longer is Eligible as a Dependent.

Section 6 – Special Circumstances for a Child Who is a Full-Time Student Check Your Benefits Chart for Details

A Child, who is 19 or older, but who is less than the Limiting Age (**See Section 35**), may continue as an Eligible Dependent if he/she meets all of the following:

A. Is a Full-Time Student (**See Section 35**) attending classes in an accredited educational institution.

B. Is not married.

C. Depends on You for principal support according to IRS Dependency Guidelines (**See Section 35**).

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

Section 7 – Special Circumstances for a Child With a Disability
Check Your Benefits Chart for Details

A. Permanent Disability

A Child, who cannot take care of himself because of a Permanent Mental or Physical Disability (**See Section 35**) may continue as an Eligible Dependent if:

1. The Child became incapacitated while insured as a Dependent by AultCare, or by another health care plan, before that Child reaches the age of 19 (or in the case of a Full-Time Student, before the Child reached the Limiting Age), so long as there was continuous Coverage with no lapse or break.

2. The Child is not married.

3. You give proof of incapacity. We may request proof once each year.

B. Temporary Disability

A Child who is a Full-Time Student (**See Section 6 and Section 35**) who is unable to attend classes because of a temporary mental or physical disability, may continue as an Eligible Dependent if:

1. The Child meets, at least, 2 out of the 5 IRS Dependency Guidelines (**See Section 35**).

2. You apply for continued Coverage, and continued Coverage is approved.

Section 8—Enrollment
Check Your Benefits Chart for Details

A. Enrollment

Enrollment means You completed and signed an Enrollment Application for Coverage and Benefits under the Policy for You and Your Dependents.

B. Initial Enrollment

Initial Enrollment is when a new Enrollee completes an Enrollment Application. You may apply for Individual Coverage or Family Coverage. With Individual Coverage, only the Enrollee is Eligible for Coverage and Benefits under the Policy. If the Enrollee enrolls for Family Coverage, then the Enrollee's Dependents may be Covered.

If You apply for Family Coverage, the Enrollee must list all Eligible Dependents to be covered. Dependents who are Eligible to enroll at the time of Initial Enrollment must be enrolled at that time or the Enrollee will not be allowed to enroll those persons.

C. <u>Dependent Special Enrollment</u>

Dependent Special Enrollment is a **31** calendar day period when an Eligible Dependent of an Enrollee may enroll because of marriage, birth, adoption, or placement for adoption. An Eligible Dependent also may enroll during the Dependent Special Enrollment Period if that Dependent did not enroll because of other Coverage, which that Dependent no longer has.

D. <u>How to Enroll</u>

To enroll for Coverage and Benefits under the Policy, You must timely complete an Enrollment Application.

E. <u>How to Add a Dependent</u>

To add an Eligible Dependent, contact Us as soon as possible. Fill out and return an Enrollment Application within **31** calendar days from the date of marriage, birth, adoption, placement for adoption or other Triggering Event (**See Section 35**).

F. <u>How to Drop a Dependent</u>

To drop a Dependent, contact Us as soon as possible.

G. <u>When You Need to Update Enrollment Information</u>

There are times when You must update Enrollment information. For example, You must end Coverage for an ex-Spouse in a divorce. You must give us a time-stamped Divorce Decree. You must end Coverage for a Child who is **19** years or older, unless that Child is a Full-Time Student or unless the Dependent Child is disabled.

Contact Us as soon as possible to update, change or end Coverage for Yourself or for a Dependent.

Section 9–Coverage
Check Your Benefits Chart for Details

A. <u>What Coverage Means</u>

Coverage means that period when You and Your Dependents are Eligible to receive Benefits for Covered Services under the Policy.

B. <u>Pre-Existing Condition Exclusionary Period (Also See the HIPAA Portability Section)</u>

1. A Pre-Existing Condition Exclusionary Period may apply.

2. A Pre-Existing Condition (**See Section 35**) means a medical condition (physical or mental) for which You or Your Dependent were treated during the **6** months before You or Your Dependent Enrolled for Coverage under this Policy.

3. Coverage and Benefits are not payable for certain Pre-Existing Conditions during the Exclusionary Period (**See Section 35**), if applicable, which may be up to **12** months, or up to **18** months for Late Applicants (**See Section 35**). After the Exclusionary Period, treatment for the Pre-Existing Condition will be Covered.

4. The Pre-Existing Condition Exclusion will not apply to pregnancy, newborns or Federally Eligible individuals.

C. Creditable Coverage

1. The Pre-Existing Exclusionary Period may be reduced by the length of the period of any Creditable Coverage (**See Section 35**).

   Creditable Coverage means the time the individual had Coverage under a group health plan, health insurance coverage, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a State health benefits risk pool, a health plan offered under chapter 89 of title 5, United States Code, a public health plan as defined in regulations, a health benefit plan under section 5(e) of the Peace Corps Act, or other similar health care provision.

   Creditable Coverage is not counted if there is a break in Coverage of **63** calendar days or more (other than for an applicable waiting period) between the end of the Creditable Coverage and Your Enrollment Date under the new Coverage. You must give Us a Certificate of Creditable Coverage (**See Section 35**) from Your prior plan or insurer to reduce the Pre-Existing Exclusionary Period.

2. AultCare will provide You with a certificate of Creditable Coverage when Your Coverage with Us ends.

D. Questions

Check Benefits Chart. Call Us if You have questions about the Pre-Existing Medical Condition Exclusion Period and Creditable Coverage.

Section 10—Coverage for Enrollees and Dependents
Check Your Benefits Chart for Details

A. When Coverage Begins

Coverage for You and Your Enrolled Dependents begins on the earlier of:

1. The day immediately following the date Your Coverage under Your prior group health insurance policy terminated, provided You have completed Your Enrollment Application and submitted the Premium within the time frame provided under Ohio law.

2. The date you complete and sign Your Enrollment Application and pay the required Premium.

B. To Add a Newly Eligible Dependent

1. To add a newly Eligible Dependent, tell Us within **31** calendar days of the Triggering Event, such as marriage, birth, adoption or placement for adoption. If You fail to do so, that person will not be Eligible for Coverage under this Policy.

2. Fill out the Enrollment form if You are adding a newborn (or adopted child). Include the newborn Dependent's name, social security number (if available), date of birth (or other Triggering Event) and Coordination of Benefits information. If the newborn does not yet have a social security number, You may submit the Enrollment form without the newborn's social security number. Please apply for a social security number right away. Once You get it, provide it to Us.

3. If the Dependent is Your stepchild, include a copy of a complete, official, time-stamped and recorded final divorce decree or court order that indicates who is responsible for health coverage.

4. If the Dependent is 19 or older and is going to school, fill out the section on Full-Time Students.

C. Date Dependent Coverage Takes Effect

1. Coverage will become Effective on the date of the Triggering Event, provided the individual was enrolled within 31 days of the Triggering Event.

2. On the date of birth for a Child born after the Effective Date of Your Coverage. Coverage for that Child will stay in effect for the first **31** calendar days following birth. You must notify Us of the birth and request Coverage for that Child within the **31** calendar day period following the Child's birth in order to continue Coverage after **31** calendar days. You may need to pay an additional Premium.

D. To End Dependent Coverage

1. To end Coverage for a Dependent, tell Us within **31** calendar days from the Triggering Event (**See Section 35**).

2. We will give you a form to remove the Dependent from Your Plan.

3. If Your Spouse (**See Section 35**) is ending Coverage as a Dependent, he or she must sign the Enrollment form stating that he or she no longer is Covered by Your Plan. If Your ex-Spouse does not sign because of divorce, We may require You to give Us a copy of the official, time-stamped and recorded final divorce decree

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

E. Date When Coverage Ends

Your Coverage will end on the earliest of the following:

1. For a Dependent, the date that person no longer meets the definition of Dependent in this Policy;

2. The date We determine that You have committed fraud or intentional material misrepresentation against Us;

3. For nonpayment of Premium, the last day of the period of time for which You paid Premium, subject to the grace period; or

4. When We cease to offer a type of policy or cease to do business in the individual medical insurance market, as applicable and as allowed by state requirements.

   (a) If We decide to discontinue offering this type of policy:

      i. You will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such Coverage; and

      ii. You will be given the option to purchase any other similar policy providing medical benefits that We offer at such time.

   (b) If We decide to cease doing individual medical insurance business in this state, We will provide You and the Commissioner of Insurance with notice of such discontinuation at least 180 days prior to the discontinuation of such Coverage.

5. The date You no longer reside in the State of Ohio.

Section 11—Converting To An Individual Healthcare Coverage Contract

A. Dependent Eligibility

Each of Your Covered Dependents has the right to obtain an individual healthcare Coverage contract if the Dependent's Coverage under this Policy ends for one of the following reasons:

a. Your death.

b. Your Spouse ceases to be an eligible Dependent due to divorce or annulment.

c. Your Covered Dependent Child reaches the Limiting Age.

d. Your covered Dependent Child ceases to be an eligible Dependent for any other reason.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

B. Payment and Effective Date

If a Dependent is Eligible for an individual healthcare Coverage contract, they must apply for it and pay the required Premium directly to AultCare within **31** calendar days after Coverage for that person ends. Evidence of good health is not required.

After AultCare receives a valid application and payment, the individual healthcare Coverage contract will take effect within **31** calendar days after Coverage ends.

C. Benefits

Benefits under the individual healthcare Coverage contract may differ from the Coverage under this Policy.

D. End

Your Policy will end if You do not pay Your Premium, or if Medicare becomes Your primary insurance.

E. Questions

Email Us at www.aultcare.com, or Call Us at (330) 363-6360 or 1-800-344-8858 if You have questions.

Section 12—Guaranteed Renewability

You may cancel this Policy at any time by written notice delivered or mailed to Us. Cancellation is effective upon receipt or on such later date as may be specified in Your notice. In the event of cancellation, We will return promptly the unearned portion of any Premium paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Except as set forth in Section 10 - "Date When Coverage Ends" section of the Policy, We may not cancel this Policy.

Section 13—Using Network Providers
Check Your Benefits Chart for Details

A. Services from Network Providers

1. The level of coinsurance You receive under the Policy may be greater, and the amount You must pay Out-of-Pocket may be less, if You receive Covered Services from Network Providers.

2. Network Providers are listed in the Plan Directory, which is on Our website www.aultcare.com.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

3. If Your Doctor no longer is a Network Provider, call Us. In some cases, We may continue to pay for Covered Services at the Network Provider rate for a period of time to let You complete a course of treatment. We also will help You find a new Network Provider.

B. <u>Services from Non-Network Providers</u>

1. When You choose a Non-Network Provider, You may be responsible for more out-of-pocket. Charges that exceed the Usual, Customary and Reasonable rates (also called "UCR." **See Section 24 and 35**) are not Covered. You may need to pay more Out-of-Pocket Expenses (**See Section 35**). Check Your Benefits Chart.

2. Services by a Non-Network Provider may be Covered at the same level as a Network Provider, if Your Network Provider Refers You to a Non-Network Provider because that Non-Network Provider offers Medically-Necessary Covered Services that are not offered by Network Providers, and AultCare Pre-Approves the Referral, but Referral and Pre-Approval do not guarantee that Benefits will be paid at the highest Benefit Level, or at all. Charges that exceed UCR are not Covered.

C. <u>Emergencies or When You are Out of Town</u>

You may use Non-Network Providers for appropriate Emergency Care or Urgent Care when You are out of town. (**See Section 17 and Section 35**). Check Your Benefit Chart.

D. <u>Emergencies When You are Traveling Out of the USA</u>

Generally, we may pay for limited Emergency Services that are necessary when You are traveling out of the USA. We will consider each Claim carefully. We will not pay for Services when You go to another country to obtain medical care. We do not pay for air transport or medical evacuation. We recommend that You obtain separate medical travel and evacuation insurance if You plan to travel out of the USA.

Section 14—Covered Services (Benefits)
Check Your Benefits Chart for Details

A. <u>General Description of Covered Services (Benefits)</u>

Covered Services are medical and health Benefits that You and Your Eligible Dependents may receive under the Policy (**See Sections 14 through 19**).

B. <u>Maximum Amount of Eligible Expenses for Benefits</u>

The Maximum Amount of Eligible Expenses (**See Section 35)** for Benefits is in Your Benefits Chart.

C. <u>Questions about Benefits and Eligible Expenses</u>

Contact Us if You have questions about Covered Services and Benefits.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

Section 15—Covered Outpatient Services
Check Your Benefits Chart and Your Exclusion List for Details

We Cover certain Outpatient Services. You will need to make applicable Co-Payments and Coinsurance. Check Your Benefits Chart. Also check the Exclusions that appear at the beginning of this Policy.

Outpatient Services may include:

A. Physician Office Visits

Office Visits (**See Section 35**) to Your Physician for treatment of illness or injury. (**Also see Section 18** for Preventive Care Services).

B. Gynecology Visits

Office visits to Your gynecologist for Medically Necessary (**See Section 35)** examinations. (**Also see Section 18** for Preventive Care Services).

C. Office Visits to Medical and Surgical Specialists

Necessary and appropriate Office Visits **(See Section 35)** to medical and surgical specialists.

D. Diagnostic Services

Diagnostic Services such as laboratory, X-ray, cardiographic, encephalographic, electromyographic, endoscopic and organ exams.

E. Outpatient Surgery

Medically Necessary surgical procedures and anesthesia. Your Network Provider may handle Pre-Approval, if needed. Some Elective Surgeries may need a Second Surgical Opinion. Check Your Benefits Chart to see if penalties apply if You are not Pre-Approved.

F. Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy when:

1. Care is received from a licensed therapist acting within the scope of his or her license.

2. Treatment is prescribed in writing by a Doctor who receives progress reports.

3. Treatment for rehabilitation purposes is necessary as a result of a loss of function following a medically documented acute illness or injury.

4. When the patient fails to improve any further, even with therapy, Coverage will be discontinued.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

G. Allergy Testing and Treatment

Appropriate and necessary allergy testing and treatment up to the Maximum Benefit. See Your Benefits Chart.

H. Mental Health and Alcohol/Substance Abuse Services

Except for the treatment of Biologically Based Mental Illnesses, Benefits payable for mental health and alcohol/substance abuse care are different from those paid for the treatment of other physical illness or injury.

1. Outpatient Mental Health Services

   We will Cover Outpatient psychotherapy up to the Plan Maximum. Check Your Benefits Chart.

2. Outpatient Alcohol/Substance Abuse Services will be Covered when:

   a. Pre-Approved.

   b. These Services are appropriate instead of an inpatient stay.

Bed and nursing Services are not Covered. Benefits payable for Covered Mental Health and Alcohol/Substance Abuse Services are subject to Annual and Lifetime Maximums. Check Your Benefits Chart.

Section 16– Covered Inpatient Hospital Services
Check Your Benefits Chart for Details

A. Inpatient Hospital Services for Treatment of Physical Injury or Illness

We will Cover all Inpatient Hospital Services which need Pre-Approval. Network Providers may get Pre-Approval for You. You must make sure that Your Non-Network Provider gets Pre-Approval for You. You must make sure that You get Pre-Approval before You go to a Non-Network Facility. (**See Section 21 and Section 35**).

Inpatient Hospital Services may include:

1. Semi-private room and board.

2. Doctors' Services related to medical treatment or surgery.

3. General nursing Services.

4. Diagnostic Services, such as laboratory, X-ray, cardiographic, encephalographic, electromyographic, and endoscopic and organ exams.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

5. Operating room, anesthesia and supplies.

6. Medically Necessary supplies and Services, such as:

   a. Oxygen, including necessary equipment for its administration.

   b. Blood and blood plasma (if not replaced), and other fluids to be injected into the circulatory system.

   c. Braces, crutches, casts, splints, trusses, surgical dressings and ostomy supplies.

7. Prescribed drugs given while in the Hospital.

8. Physical Therapy, Occupational Therapy, and Speech Therapy up to the Plan Maximum when:

   a. Care is received from a licensed therapist acting within the scope of his license.

   b. Treatment is prescribed by a written order from a Doctor who receives progress reports.

   c. Treatment for rehabilitation purposes is necessary as a result of a loss of function following a medically documented acute illness or injury.

   When the patient fails to improve any further even with therapy, Coverage up to the Plan Maximum will be discontinued.

9. Services for human organ and tissue transplants, if Pre-Approved by the UM Department, and performed in an AultCare-approved facility. See Your Benefits Chart.

B. <u>Inpatient Treatment for Mental Health and Alcohol/Substance Abuse</u>

We will Cover Inpatient treatment for Mental Health and Alcohol/Substance Abuse Services only if:

1. Pre-Approved.

2. Service is provided for the diagnosis, evaluation or treatment of a mental illness or alcohol/substance abuse condition that is subject to favorable modification. Benefits are not payable for the treatment of mental deficiency or mental retardation once diagnosed. Benefits are payable for inpatient treatment of a mental and/or alcohol/substance abuse condition.

3. Services are provided at a Hospital Facility that is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations. A free-standing facility that is not a part of a Hospital may not qualify as a Hospital Facility for purposes inpatient treatment. Check with Us at the time You request Pre-Approval.

Section 17 – Emergency and Urgent Care Services
Check Your Benefits Chart for Details

A. Emergency Services

If You have an Emergency Medical Condition, go immediately to the nearest hospital or call 911 for Emergency Services. 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 the 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 Benefits Chart no matter when or where You receive them. If You go to a Non-Network Provider, payment may be limited to UCR (**See Section 24 and Section 35**).

Emergency Services do not need to be Pre-Approved before you seek treatment. If You are admitted to the Hospital that is a Non-Network Provider through its Emergency Department as a result of Emergency Services for an Emergency Condition, You must inform AultCare within **2** business days after receiving care, or as soon as You can. This will allow a Case Manager (**See Section 1 and Section 35**) to follow Your care. AultCare's UM Department (**See Section 1 and Section 35**) may review Your Claim for Emergency Services to determine if Emergency Services were Medically Necessary. If, after applying the prudent layperson standard, the UM Department determines that services were not Emergency Services, they may be non-approved. Check Your Benefits Chart.

B. Urgent Care Services

Urgent Care Services are health care Services that are appropriately provided for an unforeseen condition that usually requires medical attention, without delay, but which does not pose a threat to the life, limb, or permanent health of the injured or ill person.

Urgent Care treatment for a condition defined above does not have to be Pre-Approved. Payment may be limited to UCR (**See Section 24 and Section 35**) if You receive Urgent Care treatment at a Non-Network Facility.

Section 18 –Other Covered Services
Check Your Benefits Chart for Details

We generally may Cover the following Services:

A. Ambulance Transportation Services

Ambulance Transportation (**See Section 35**) to the nearest Hospital in an Emergency, or when Pre-Approved in non-Emergency situations. Transportation must be by a licensed, professional ambulance Service.

B. Breast and Cervical Cancer Screening

Breast and cervical cancer screening to detect breast or cervical cancer. Screening may be at a Hospital, Physician office or mobile unit.

C. Centers of Excellence

Certain Medically Necessary Services by an AultCare approved Non-AultCare Centers of Excellence Provider will be Covered at the same level as an AultCare Provider if such services are not offered by AultCare Providers. Pre-Approval is required for these services to be Covered by an AultCare approved Non-AultCare Centers of Excellence Provider at the AultCare Provider level with no UCR.

D. Chiropractic Services

Chiropractic Services from a licensed Chiropractor when Chiropractic Services are Medically Necessary to treat dislocations and subluxations of the vertebrae. We do not Cover Chiropractic Maintenance Care (**See Section 35**). Chiropractic care is subject to review by our UM Department. Services ordered or done by Your Chiropractor are subject to Co-Payments, Annual Maximum limits and Coverage Exclusions. Check Your Benefits Chart.

E. Dental Services

Certain Dental Services, such as treatment for injuries to natural teeth caused by an Accident, including the initial replacement of these injured teeth, tumors, cysts and removal of impacted teeth, are considered medical expenses and are paid as such, provided the treatment is given within ninety (90) days of the Accident. Check Your Benefits Chart.

F. Durable Medical Equipment

Rental or purchase of Durable Medical Equipment (**See Section 35**), including supplies, if:

1. The equipment or supply is for Your use only.

2. The equipment has a life up to **6** months.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

3. The equipment or supply is primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury.

4 The equipment improves the function of a malformed body member or retards further deterioration of Your physical condition.

5. The equipment or supply can effectively be used in a non-medical facility (Your home).

6. The equipment or supply can be expected to contribute meaningfully to the treatment of the illness or injury.

7. Your Doctor certifies that the equipment is Medically Necessary.

8. The equipment is furnished by a licensed DME supplier.

G. Home Healthcare Service

Home Healthcare Services (**See Section 35**) must be ordered by a Doctor (**See Section 35**) as part of a treatment plan that is approved by the UM Department (**See Section 1 and Section 35**) before the first day of care. We have the right to request a new treatment plan and confirm certification every **30** calendar days.

1. We may Cover Home Healthcare Services when:

   a. The patient is essentially confined to the home.

   b The patient requires on an intermittent basis: nursing Services; therapy; or other Services provided by a certified Homecare Program.

   c. Services are performed by, or under direct supervision of, a licensed Registered Nurse or Licensed Practical Nurse according to the treatment plan. The plan must be periodically reviewed and re-certified by the Doctor who is responsible for the patient's care.

   d. Care is not Custodial or Maintenance.

2. We will pay Benefits for the following Services and supplies if Medically Necessary:

   a. Professional Services of a Registered Nurse (**See Section 35**), Licensed Practical Nurse (**See Section 35**), or Certified Homecare Aide (**See Section 35**), if the Services of a Registered Nurse or Licensed Practical Nurse are not available.

   b. Physical Therapy, Occupational Therapy, Speech Therapy, and Respiratory Therapy.

   c. Medical supplies and medicines prescribed by the Doctor responsible for the patient.

d. Laboratory Services provided by or on behalf of a Hospital, but only if they would have been Covered under the Policy if the patient were in the Hospital.

3. Annual Maximum.

Home Health Care Benefits may have an Annual Maximum (**See Section 35**). Check Your Benefits Chart.

H. Hospice Care

1. Conditions for Hospice Coverage:

a. A Doctor has diagnosed You as having a Terminal Condition with a short life expectancy of **6** months or less.

b. Your Doctor refers You to Hospice.

c. You are treated in a qualified Hospice Care Program by a qualified Hospice Team.

2. Covered Hospice Services:

a. All Covered Home Healthcare Services listed above, except nursing Services which may be approved for up to **8** hours in any **24** hour period.

b. Palliative Services and supplies furnished by the Hospice team, including part-time nursing care by, or under the supervision of, a Registered Nurse.

c. Dietary guidance.

d. Durable Medical Equipment.

e. Limited Bereavement counseling.

f. Home health aide visits.

g. Limited spiritual counseling Services.

3. We Do Not Cover:

a. Homemaker Services.

b. Volunteer Services.

c. Chemotherapy or radiation therapy, if other than Palliative (**See Section 35**).

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

d. Curative treatment or Services.

e. Food or home-delivered meals and Custodial care (**See Section 35**).

f. Rest care or care for someone's convenience.

g. Transportation Services

h. Services or supplies not provided and billed through the Hospice Care program.

I. Infertility Diagnosis/Treatment

We may Cover the cost for infertility diagnosis and surgical treatment that are Medically Necessary. Check Your Benefits Chart and list of Exclusions.

J. Maternity Services

1. Maternity Services include:

   a. Hospital charges related to Your pregnancy.

   b. Pre-natal and Post-natal care.

   c. Treatment for complications of pregnancy or childbirth, and any obstetrical disorder, injury or condition arising from childbirth.

   Maternity Services do not include care for a Dependent's child (grandchildren) unless You adopt.

2. Hospital Admissions.

   Coverage includes a **48**-hour Hospital admission for routine vaginal delivery and a **96**-hour Hospital admission for routine caesarian section delivery. Please inform the UM Department (**See Section 1**) of Your expected delivery date. The Hospital stay may be extended if approved by the UM Department. If discharge is prior to applicable hours, follow-up care may be provided for **72** hours after discharge.

3. Emergency Deliveries.

   Emergency deliveries are Covered, regardless of provider, when You notify the UM Department within **two** business days after the delivery, or as soon as You can.

K. Orthotics

Orthotics are foot devices that do more than support the feet. They must restore function. To be Covered, orthotics must meet the same requirements as Durable Medical Equipment.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

L. <u>Podiatry Services</u>

We may Cover Medically Necessary treatment by a Podiatrist. Routine foot care is not Covered. Podiatric Services ordered or performed by Your Podiatrist may be subject to Copayments and Annual Maximum limits.

M. <u>Preventive Health Services</u>

We may Cover Preventive Health Services (**See Section 35**) and supplies ordered and provided by or under the direction of a Doctor in the Doctor's office. Coverage includes tests, screenings and Services, such as:

1. Well-Child Care, including immunizations. (**See Section 35**) Check Your Benefits Chart.

2. Screening such as cholesterol.

3. Blood pressure checks.

4. Screening mammograms.

5. Routine Pap smears/Cytologic screening for the presence of cervical cancer at least yearly or more often if Medically Necessary.

6. Physicals

Check Your Benefits Chart for Annual Maximums (**See Section 35**).

N. <u>Private-Duty Nurses</u>

Services provided by Private-Duty Nurses to You or Your Covered Dependent while in the Hospital may be Covered only if they are Medically Necessary and they have been Pre-Approved by Our UM Department (**See Section 1**).

O. <u>Prosthetic Devices</u>

Expenses are Covered for the purchase, fitting, necessary adjustments and replacements of prosthetic devices and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues.

2. Replace all or part of the function of a permanently useless or malfunctioning body part.

3. Certified by a physician as being Medically Necessary.

Benefits for prosthetic appliances include lens(es) following cataract surgery.

P. Reconstructive Surgery Following Mastectomy

We will Cover Reconstructive Surgery of the breast on which a mastectomy was done and on the other breast to give symmetrical appearance. We will Cover Prostheses and treatment of physical complications at all stages of mastectomy, including lymph edemas.

Q. Routine Patient Care

We will cover Routine Patient Care administered to an insured participating in any stage of an eligible cancer clinical trial, if that care would be covered under the plan if the insured was not participating in a clinical trial. Eligible cancer clinical trial will meet the following criteria:

1. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.

2. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.

3. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.

4. The trial does one of the following:

   (a) 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;

   (b) Tests responses to a health care service, item, or drug for the treatment of cancer;

   (c) 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;

   (d) Studies new uses of a health care service, item, or drug for the treatment of cancer.

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

   (a) The National Institutes of Health or one of its cooperative groups or center under the United States Department of Health and Human Services;

   (b) The United States Food and Drug Administration;

   (c) The United States Department of Defense or Department of Veterans Affairs.

R. Skilled Nursing Facility

1. We Cover Medically Necessary Skilled Nursing Facility Services (**See Section 35**) that are approved by the UM Department (**See Section 1 and Section 35**) when:

   a. Care is provided by a Skilled Nursing Facility.

   b. You are admitted to the Skilled Nursing Facility within **14** calendar days after being discharged from the Hospital and You are receiving care for the same condition for which You were hospitalized.

   c. Care is not Custodial (**See Section 35**).

2. We Cover Medically Necessary Skilled Nursing Facility Services by Non-Network Providers if:

   a. You resided in the Skilled Nursing Facility, or had a contract to reside in the facility, on or before September 1, 1997.

   b. Immediately before You were hospitalized, You were in the facility, or have a contract to reside in the facility, and following hospitalization, reside in a part of the facility that is a Skilled Nursing Facility, even if You resided in, or had a contract to reside in, a different part of the facility before You were hospitalized.

   c. The facility provides the level of Skilled Nursing care You need.

   d. The facility is willing to accept from AultCare all of the same terms and conditions that apply to a facility that provides Skilled Nursing care and is a Network Provider.

S. Transplants

1. Transplants Covered

   We Cover Medicare-approved transplants, including:

Bone Marrow	**Heart-Lung**	**Lung**
Cornea	**Kidney**	**Pancreas**
Heart	**Liver**	

Covered charges
Initial testing and diagnosis; immunosuppressant drug therapy before and after surgery; complications resulting from surgery, organ rejection/failure; and repeat transplants of same organ.

We do not cover transplants that are Experimental or Investigational or those that are in clinical trials, with the exception of services relating to Routine Patient Care.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

2. Pre-Approval

All non-Experimental organ and tissue transplants must be Pre-Approved by the UM Department and performed at an approved Facility. If services are performed at an approved Health Care Facility, travel and lodging will be covered for the recipient and companion. The maximum overall coverage shall be limited to $10,000 per covered transplant procedure. The maximum daily coverage for lodging and meals shall be limited to $250 per day.

3. Coverage

Coverage for Services and supplies provided in connection with an organ transplant procedure include:

a Recipient Costs

When You or Your Dependent is the recipient, Benefits are paid for recipient costs.

b. Donor Costs

When You or Your Dependent is the donor, Benefits are paid for donor costs.

When You or Your Dependent is the recipient, but You or Your Dependent are not the donor, only those expenses of the donor not paid by the donor's plan may be eligible expenses. Benefits may be payable only to the extent they are available under the recipient's plan.

c. Limits

If You or Your Dependent are not the donor, Benefits for donor costs are limited to costs directly related to the transplant procedure and related complications. Benefits do not include any medical care costs related to other treatment of the donor. Donor transportation costs are excluded. No Benefits for recipient or donor costs are payable for Experimental, Investigational or are performed in clinical trials, with the exception of services relating to Routine Patient Care. Check Your Benefits Chart.

T. Routine Vision Care

We may Cover the cost of an initial eye examination following cataract surgery, including the initial cost of lenses and frames. Check Your Benefits Chart.

Section 19 – Managed Prescription Drug Program

We provide prescription drug Coverage through a Managed Prescription Drug Program. To get the highest level of Benefits, You must get Your prescription from an AultCare Participating Network Pharmacy. It is important for You to show Your AultCare ID Card.

We may change the required Co-Payments, Coinsurance, or the Formulary at any time if we give You timely written notice.

A. AultCare Participating Network Pharmacy

If You get Your prescription filled by an AultCare Participating Network Pharmacy, You will pay the greater of:

1. Your minimum Co-Payment amount, depending on whether the drug is Generic, a Brand-Name on the Formulary, or a Brand Name that is not on the Formulary, or

2. Your applicable Coinsurance amount.

Check Your Benefits Chart for Your level of Coverage and required Co-Payments or Coinsurance.

B. Non-Network Pharmacy

If You get Your prescription filled by a Non-Network Pharmacy, You must pay the greater of:

1. Your minimum Co-Payment amount, depending on whether the drug is Generic, a Brand-Name on the Formulary, or a Brand-Name that is not on the Formulary, plus the Cost Variance, or

2. Your applicable Coinsurance plus the Cost Variance.

Call Us at (330) 363-6360 or 1-800-344-8858 or check our website at www.aultcare.com to get a copy of the Formulary and list of Participating Network Pharmacies.

Section 20—Exclusions

A. Exclusions

An Exclusion means a procedure, condition or Service that the Policy does not Cover. Exclusions appear at the beginning of this Policy. Please check them carefully.

B. Receiving Services that are Not Covered (Excluded Services)

You may receive Services that are Not Covered (Excluded Services), but You must pay for them Yourself. You should make arrangements in advance with Your Doctor or health care Provider on how to pay for Non-Covered Services.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

Section 21 –Pre-Approval, Concurrent Review, Second Opinions

Our UM Department (**See Section 1 and Section 35**) may require Pre-Approval, Concurrent Review and Second Surgical Opinions.

A. Pre-Approval

1. Pre-Approval (also called "Pre-Certification" or "Pre-Authorization") means You or Your Network Provider must notify UM 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 Pre-Approval. Pre-Approval is needed to help determine if other appropriate medical care possibilities have been explored and are within acceptable time elements. Pre-Approval is a separate process from Benefit Determination. The fact that a Provider referred You for certain Services, or that Pre-Approval was given, does not guarantee that Your Claim will be paid at the Network Provider level, or at the highest Benefit Level, or at all.

2. You need to be Pre-Approved when:

    a. You are admitted to the Hospital.

    b. You need to be seen by a Non-Network Provider, and You seek payment at the Network Provider rate.

    c. You need Durable Medical Equipment in the amount stated in Your Benefit Chart.

3. How to Request Pre-Approval:

    a. Network Providers will call the UM Department for You to get Pre-Approved

    b. If You use a Non-Network Provider, You must call the UM Department to ask for Pre-Approval before You receive Services.

    c. You must be Pre-Approved within **2** business days from when You become a Hospital inpatient.

4. If You do not get Pre-Approved:

    a. A Monetary Penalty may be applied, which will reduce the payment to the Provider. You may be required to pay the unpaid amount.

B. Concurrent Review

Concurrent Review is done by AultCare nurses in the UM Department when:

1. You are in the Hospital.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

2. You have ongoing mental health or alcohol/substance abuse treatment.

3. You have Home Health Care Services.

4. You are receiving Health Care goods or Services that continue over an extended period.

C. <u>Second Surgical Opinions</u>

AultCare, at times, may require a Second Surgical Opinion. Check Your Benefits Chart

Section 22—Using Your AultCare ID Card

A. <u>Information On Your Card</u>

On the <u>front</u> of Your AultCare ID Card, You will find:

1. Your name.

2. Your Enrollee Identification Number.

3. Whether Your Coverage is Individual or Family.

4. The Effective Date of Coverage.

5. The amount of Your Co-Payment.

On the <u>back</u> of Your AultCare ID Card, You will find:

1. Our address, including where You can submit Claims

2. Our website www.aultcare.com.

3. Our Service Center telephone numbers, (330) 363-6360 and 1-800-344-8858.

4. Our weekday hours of operation.

5. The telephone number You must call to obtain Pre-Approval from our UM Department.

B. <u>When You Need to Show Your AultCare ID Card and Why</u>

You will need to show Your AultCare ID Card when You go to a Provider for Services. Your Doctor or healthcare Provider will verify that You are Covered by checking Your Enrollee Number and Member ID

Number. If You change Your Coverage from Individual to Family or from Family to Individual, You will get a new AultCare ID Card. Always bring Your most current AultCare ID Card with You.

Section 23—Your Responsibility for Co-payments, Deductibles, Co-Insurance Check Your Benefits Chart for Details

A. Your Responsibility for Co-Payments

A Co-Payment (or Co-Pay) is the set dollar amount You pay Out-of-Pocket for each Provider Office Visit. The Co-Pay does not count against Your Annual Deductible or Out-of-Pocket Maximum. Check Your Benefits Chart. The amount of Your Co-Pay is on the front of Your AultCare ID card.

B. Your Responsibility for Deductibles

A Deductible means a set annual dollar amount of medical expenses You must pay before the Policy pays. Check Your Benefits Chart.

C. Co-Insurance

Co-insurance is the percentage of medical expense You share with the Policy after You meet Your Annual Deductible.

Section 24—Usual, Customary, and Reasonable ("UCR")

We are committed to offering You health care benefits for Covered Services at reasonable rates. Your benefits are greatest when you receive Your Health Care Services and treatment from a Network Provider.

Some plans require enrollees to stay within the Network. We permit You to go outside the Network. If you go outside the Network, however, You will be responsible for paying what We do not pay, since We have no control over what Non-Network Providers charge.

The amount We pay to a Non-Network Provider often is less than the Non-Network Provider charges and may be less than the negotiated fee We pay to a Network Provider for the same Service. You are responsible for paying the balance of fees the Non-Network Provider charges. Consequently, there may be a financial incentive for You to use Network Providers.

Before choosing a Non-Network Provider, We encourage You to find out what the Non-Network Provider charges for a particular service and what We will pay for that service. We also suggest that You compare what We will pay for the Non-Network Provider's service to the amount We would pay if the service were furnished by a Network Provider. You may contact the Service Center for assistance.

"Usual, Customary and Reasonable Charges" or "UCR" means allowable fees for Covered Services.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

A. For Network Providers, UCR means the professional fees We have negotiated with them.

B. For Non-Network Providers, UCR means a fee level that We have determined to be appropriate for a particular medical service, which often is less than the providers actually charge.

C. We will not pay that portion of Non-Network Provider fees that exceeds UCR. You may be responsible for paying that amount.

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

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

Section 25—Filing Your Claim

A. Claims for Hospital Services

When Services are provided at a Hospital, show Your AultCare ID Card and sign the Hospital assignment form. The Hospital will send to AultCare a Claim for Services provided to You.

B. Claims For Provider Office Visits

1. Your Network Provider will file Your Claim for You.

2. If You go to a Non-Network Provider, You may need to use an Application for Benefits form. You can get a copy of this form on-line by going to Our website www.aultcare.com or by calling Us at (330) 363-6360 or 1-800-344-8858. Fill it out and sign the top half of this form. Be sure to answer all questions. Give the form to the Non-Network Provider and ask him or her to complete the bottom half. Either You or the Non-Network Provider must then send the completed form to Us at the AultCare Service Center, P.O. Box 6910, Canton, Ohio 44706. In some cases, You may be able to attach an itemized statement from Your Non-Network Provider instead of having the Non-Network Provider complete the bottom half of the form.

   Payment Cannot Be Made On Any Bill Until Your Properly Completed Application for Benefits Is Filed.

C. Time Limits for Filing Claims

Generally, You must file a Claim within **15** months from the date You received Service, unless You are not reasonably aware that it must be filed because of Coordination of Benefits or Subrogation.

D. Questions

If You have a question about Your Claim, how to fill out the Application for Benefits form, or whether You can send in an itemized statement, click onto our website at www.aultcare.com, or call Us at (330) 363-6360 or 1-800-344-8858.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

Section 26—Your HIPAA Privacy Rights

The confidentiality of Your Claim and health information is very important to Us. We have adopted policies and procedures to safeguard Your Protected Health Information, as required by the Health Insurance Portability and Accountability Act (sometimes known as HIPAA) and Ohio law.

When You contact Us about Your Claim, We may ask You to verify Your identity. If You are calling about a Claim for a Dependent, including Your Spouse or a child over the age of 18, then Your Spouse or Dependent will need to sign an Authorization that allows Us to discuss information, including Protected Health Information, with You. HIPAA's Privacy Rule prohibits Us from disclose another's Protected Health Information without an Authorization.

Section 27—Benefit Determination
Check Your Benefits Chart for Details

Benefits payable are determined as follows:

A. Eligible Expenses incurred during any Benefit Period may be applied against the Deductible Amount until You have paid the Deductible Amount Out-of-Pocket.

B. Outpatient Doctor's surgical and Hospital pre-admission testing charges are payable at the Benefit Percentage stated in the Benefits Chart, even if You have not met Your Deductible Amount.

C. After You have paid the Deductible Amount, Eligible Expenses will then be paid at the Benefit Percentage stated in Your Benefits Chart.

D. The Maximum Amount We will pay for all Benefit Periods may not exceed the Lifetime Maximum Benefit stated in the Benefits Chart, except if there is a minimum Annual Benefit Maximum required by law.

Section 28—Coordination of this Contract's Benefits with Other Benefits ("COB")

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY."

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

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 **Allowable 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 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** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value 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 2 or more **Plans** that compute their 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 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 second surgical opinions, precertification of admissions, and 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 have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

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 and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph (2), 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 out-of-network benefits.

C. 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**.

D. 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, member, 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:

- The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

- If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we 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

(iv) 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:

- The **Plan** covering the **Custodial parent**;
- The **Plan** covering the spouse of the **Custodial parent**;
- The **Plan** covering the **non-custodial parent**; and then
- The **Plan** covering the spouse of the **non-custodial parent**.

(c) 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. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(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, member, subscriber or

retiree or covering the person as a dependent of an employee, member, 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. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The **Plan** that covered the person as an employee, member, 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 plan 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**. McKinley Life Insurance Company 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. McKinley Life Insurance Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give McKinley Life Insurance Company 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, McKinley Life Insurance Company 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**. McKinley Life Insurance

Company 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 McKinley Life Insurance Company 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 we have not paid a claim properly, you should first attempt to resolve the problem by contacting us at 1-800-325-8424 or www.aultcare.com (for health insuring corporations, reference evidence of coverage's description of appeal procedures). If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

Section 29—Explanation of Benefits ("EOB")
Also Check Your Benefits Chart

We will send You a Explanation of Benefits (sometimes called an "EOB") that describes how We handled Your Claim. An EOB is not a bill. The Provider may send You a bill, if needed. The EOB describes:

A. The Group Number and the ID Number of the person who received Services.

B. What Services were provided, who provided them, and the date they were provided.

C. Any adjustments to show Co-Payment and Deductible.

D. Additional fee adjustments or exclusions that You are not required to pay.

E. The total amount We paid on the Claim and the date paid.

F. The amount, if any, You are responsible for paying, including Co-Insurance.

Section 30: Subrogation, Reimbursement and Other Insurance

A. Agreement

We 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, homeowners 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 policy is "excess" to several types of other insurance which may provide coverage for medical expenses. Accepting Our payment of a Benefit means You agree to all terms of Section 30.

B. What is Subrogation

When AultCare pays You a Benefit for an injury or illness that another person, plan, program or insurance company may be responsible for paying (see Section A), then You agree to give AultCare the right to get back the Benefit it paid. This is called Subrogation.

AultCare's Subrogation rights go into effect when it pays a Benefit for Covered Services. At that point, We become Subrogated to all rights You have equal to the Benefit paid (or will pay) for Covered Services for an illness or injury 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. Our 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 We have 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 is not limited to, fees and costs you actually paid, as well as fees and costs for services performed for which you or another party are responsible for paying) to receive a potential payment.

Our right to Subrogation applies even if You, any injured party, anyone with a derivative claim, any attorney, or any other person or entity are not "made whole." That means We have 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.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

C. **Reimbursement**

If You receive payment from any person or entity or through any coverage (see Sections A and B), no matter how or what You, Your legal representative or any other party may call that 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 We paid is not Yours to keep. That amount belongs to AultCare. You must pay back to Us the amount equal to the Benefit We had paid You within **14** calendar days from the date You received that payment.

Because some or all of the payment You are holding belongs to Us, 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. Our 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. Our reimbursement right will not be reduced for any attorney fees or costs **You** or any other person "incur" (see definition in Section B) 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 We "incur" (see definition in Section B) to enforce our reimbursement right.

Our 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.

D. **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's coverage under the Group Policy will be "excess" over the other collectable insurance coverage. We may require You to make a claim for that Benefit with the other collectable insurance.

E. **Your Cooperation**

You, any injured party, any attorney and any other person or entity must cooperate with Us 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 Us recover in Subrogation, Reimbursement and when there is other Insurance. You, any injured party, any attorney or any other person or entity must sign all documents for You to assign Your rights under this Section to AultCare. We may end Coverage for You if You do not cooperate as explained in this Section.

You must give AultCare any information it asks You to provide within **5** business days of its request. You must promptly notify Us of how, when and where an Accident or incident resulting in personal injury to You

occurred and give AultCare all information about the persons involved. You, any injured party, any attorney or any other person or entity must cooperate with Us in the investigation, settlement and protection of Our rights.

You, any injured party, any attorney or any other person or entity must send Us 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 Us in writing at least **30** calendar days before the settlement or compromise, and We agree to the settlement or compromise in writing.

You must complete, sign and return an accident questionnaire and/or subrogation agreement before We can process Your claim for Covered Services. We 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 our subrogation rights, Your failure to return a completed questionnaire and/or subrogation agreement within **30** calendar days, will result in the denial of Your claim. Please contact the AultCare Service Center if You have questions.

F. Discretionary Authority

We have "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 under Section 30. That means that whenever We make a determination or interpretation, it will be final and conclusive, so long as it is not "arbitrary and capricious."

SECTION 31– DETERMINATION TIME FRAMES

A. When a request for health care Coverage or Pre-Approval has been denied, You or the Provider may ask for a Reconsideration. A Doctor representing AultCare, who is familiar with Your treatment and Claim, will complete the review with the Provider who requested reconsideration. This review will take place within **3** Business Days of receipt of the written request. We will make a Determination within **2** Business Days after We receive all Necessary Information.

B. When the seriousness of Your medical condition requires more rapid Reconsideration, it will be done once the request has been received from the Provider. The Reconsideration Procedure is not required prior to the Appeal process. If the outcome of the Reconsideration is a denial, You may begin the Appeal process.

C. We will make Prospective Review Determinations within **2** Business Days after receiving all Necessary Information about a proposed admission, procedure or health care Service that needs a Review Determination.

1. We will notify the provider by phone or fax within **3** Business Days after the initial Pre-Approval.

2. If there is an Adverse Determination, we will notify the Provider by phone within **3** Business Days after making the Adverse Determination and will also let You know in writing within **1** Business day after phone Notice.

D. We will make Concurrent Review Determinations within **1** Business Day after obtaining all Necessary Information.

1. We will notify the Provider by phone within **1** Business Day after making a Determination to Pre-Approve an extended stay.

2. We will notify the Provider by phone within **1** Business Day after making an Adverse Determination, and We will let You know in writing of that Adverse Determination within **1** Business day after phone Notice.

E. We will make Retrospective Reviews within **30** calendar days after receiving all Necessary Information.

F. You may request an Internal Review (see below) if We fail to make a Determination or We fail to Notify You within the time frames stated in this Section.

G. You may have rights for other Claims Review Procedures under federal and state law. See the Statement of Responsibilities and Rights under ERISA and other Federal Law (if applicable), which appears at the end of this Certificate. Call Us if You have questions.

Section 32 –Questions, Complaints, Review and Appeals

A. Tell Us first if You have a Question, Disagreement or Complaint.

If You have a question, a complaint or You disagree with any of Our decisions or procedures, call Us first. We want to answer Your questions, address Your complaint and resolve any disagreements, if possible.

B. Types of Appeals

There are a number of appeals that are available to You if we cannot resolve disagreements, including the denial of Claims

1. Denial because Service not Covered
2. Denial because Service not Medically Necessary
3. Denial because Services are Experimental or Investigational
4. Expedited Review

C. Complaints or Quality of Care Issues

If You are not satisfied with the quality of care You received or the way We handled Your Claim, please call the AultCare Service Center at **(330) 363-6360 or 1-800-344-8858** to speak with Your Service Representative. You may email us at **www.aultcare.com.** You may write to us at:

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

AultCare Service Center
P.O. 6910
Canton, Ohio 44735-5276

We will obtain all necessary information to investigate Your Complaint. We will contact You to let You know the status or outcome of Your complaint within **30** calendar days after We receive Your complaint.

If You feel the issue is not resolved, You may file a written Complaint with Our Grievance/Appeal Coordinator. You have **60** calendar days from the date You received Our notice to file this complaint. Please send Your letter to the AultCare Service Center at the address listed above. If You need help writing a Complaint letter, please call the Service Center at **(330) 363-6360 or 1-800-344-8858**.

We will send You written notice of the outcome of Your Complaint within **30** calendar days of the request for review by the Grievance and Appeals Coordinator.

If You are not satisfied with this outcome, You may file a Complaint with:

The Ohio Department of Insurance
Consumer Services Division
50 W. Town Street
Third Floor – Suite 300
Columbus, Ohio 43215

You may also call the Consumer Services Division Hotline at **1-800-686-1526 or (614) 644-2673.**

D. Denial of Coverage

If Coverage for medical Service is denied, reduced, or terminated, You may ask Us to review the request for Service again. This is called an Internal Review. You may ask for an Internal Review when denial of Coverage is because:

1. Service is not Covered under the terms of the Plan.
2. Service is not Medically Necessary.
3. Service is Experimental or Investigational.

You, or someone acting for You, or the Provider may request an Internal Review. The Provider and health care facility must have Your consent to request an Internal Review. You do not have to pay for the Internal Review.

E. Internal Review When Denial Is Because Services Are Not Covered

If We deny the Service because it is not Covered, You may write to AultCare to request a review of Our decision. We will review Your request and the terms of the Plan as part of Our Internal Review. We will give

You a written decision within **30** calendar days from the date We receive Your request for an Internal Review. If We continue to deny Your request because it is not a Covered Service, You may ask for a review from the Ohio Department of Insurance. You can write to the Department of Insurance, Consumer Services Division, 50 W. Town Street, Third Floor – Suite 300, Columbus, Ohio 43215, or call the Department of Insurance at 1-800-686-1526.

The Department will review Your Coverage and type of Service requested. If the Department determines that the Service is not a Covered Benefit, We do not have to pay for the Service. If the Department determines that the Service is a Covered benefit, We either must pay for the Service (You will need to pay Deductibles and Co-Payments), or initiate an External Review by an Independent Review Organization. The Department will inform You of Your right to ask for an External Review if the Department cannot make a determination because it would involve the resolution of a medical issue.

F. <u>Internal Review When Denial Is Because Services Are Not Medically Necessary</u>

If We deny the Service because it is not Medically Necessary, You may ask for an Internal Review. A Clinical Peer will conduct this review. A doctor will be the Clinical Peer when the Service being evaluated for Medical Necessity is the kind of treatment provided by doctors.

The Clinical Peer will review Your medical records to determine if the Service is Medically Necessary. If the Clinical Peer determines the Service is Medically Necessary, We will Cover the Service. You still would be responsible for paying Deductibles and Co-Payments. If the Clinical Peer determines that the Service is not Medically Necessary, then We may continue to deny the Service. If the Service is denied, You may ask for an External Review by an Independent Review Organization. We will give You a written decision within **30** calendar days from the date We receive Your written request for an Internal Review. If Your medical condition needs a faster review (called an "Expedited Review"), We will provide You a response in **7** calendar days.

G. <u>Internal Review When Denial Is Because Services Are Experimental or Investigative</u>

You may ask for an Internal Review if We deny Your Claim because the Service is Experimental or Investigative. A Service is Experimental or Investigative if a majority of medical authorities consider it to be Experimental or Investigative or if it is not appropriate for Your diagnosis.

We will use a Clinical Peer for an Internal Review of a Service considered Experimental or Investigative. The Clinical Peer will review Your medical records and acceptable standard of care for patients with Your medical diagnosis. The Clinical Peer also will review information submitted by the Provider who would perform the Service, and any other clinical or professional information at the Clinical Peer's professional discretion. If the Clinical Peer determines that the Service is not Experimental or Investigative, We will Cover it. You must pay Deductibles and Co-Payments. If the Clinical Peer determines that the Service is Experimental or Investigative, We will deny Coverage. If You have a terminal illness and You meet certain legal requirements You may ask for an External Review, which may be Expedited.

Section 33—External Review

A. When You May Ask For an External Review by an Independent Review Organization

Before You ask for an External Review, You first should let Us reconsider Our denial through the Internal Review process. You may be able to skip the Internal Review process and go directly to an External Review by an Independent Review Organization. This option is at Our discretion. We 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. We 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 AultCare Service Center or the Ohio Department of Insurance.

B. External Review When Denial Is Because Services Are Not Medically Necessary

If We deny the Service because it is not Medically Necessary and the Service and related expenses will cost You more than $500 if it is not Covered (this $500 limit does not apply to Expedited Reviews), You may request an External Review from an Independent Review Organization. The Independent Review Organization is not connected with AultCare.

You must request this review within 180calendar days of receiving notice that Your Claim was denied by the Clinical Peer for lack of Medical Necessity as part of the Internal Review. Your request must be in writing and include a written statement from Your doctor or provider that the Service that has been denied will cost You more than $500 if it is not Covered.

The Independent Review Organization will review Your medical records to determine if the Service under review was Medically Necessary. If the Independent Review Organization finds that the previously denied Service is Medically Necessary, We will Cover that Service according to the terms of the Plan. If the Independent Review Organization finds that the Service is not Medically Necessary, We will not pay for it.

C. External Review When Denial Is Because Services Are Experimental or Investigative

If You have a Terminal Condition, You may ask for an External Review when Services are denied because they were determined to be Experimental or Investigative. To qualify for this External Review You must meet all of the following criteria:

1. You have a Terminal Condition that, according to the current diagnosis, has a high probability of causing death within **2** years.

2. 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.

3. Your doctor certifies that one of the following situations applies to Your condition:

    a. Standard therapies have not been proven effective in improving Your condition.

b. Standard therapies are not medically appropriate for You.

c. There is no standard therapy Covered by the Plan that will benefit You more than the therapy You or Your doctor requested.

4. Your doctor recommended a drug, device, procedure, or other therapy that he certifies in writing is likely to benefit You more than standard therapies or You requested a therapy that has been found in a majority of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.

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

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

D. Requesting an External Review by an Independent Review Organization

You must request an External Review within **180** calendar days of receiving notice of the denial 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 **30** calendar days of Your request for External Review. The decision must include:

1. A description of the patient's condition.

2. The main reasons for the decision.

3. An explanation of the clinical rationale for the decision.

If the Independent Review Organization finds that the Service is Medically Necessary, We will Cover the Service. You must pay the applicable Deductibles and Co-Payments. If the Independent Review Organization finds that the Service is not Medically Necessary, We will not Cover the Service.

Section 34—Expedited Review

A. Request for Expedited Review

When the review must be completed quickly because of Your medical condition, You may ask for an Expedited External Review by phone, fax, or e-mail. You will need to follow up any verbal request with a written request within **5** calendar days. The Independent Review Organization must give You a decision within **7** calendar days of Your request for a Expedited Review.

You may request an Expedited Review if delaying the review would do any of the following:

1. Place the health of the patient or unborn child in serious jeopardy.
2. Cause serious impairment to bodily functions.
3. Cause serious dysfunction of any body part or organ.

B. Determination by the Independent Review Organization

If the Independent Review Organization decides that the Service is Medically Necessary, We will Cover the Service. You must pay the applicable Deductibles and Co-Payments. If the Independent Review Organization decides that the Service is not Medically Necessary, We will not Cover it.

Section 35—Definitions and Index

Note: Definitions in this section, where applicable, are intended to correspond to, and be consistent with, the definitions in Ohio Revised Code, Chapters 3901, 3923 and 3924, as applicable and amended from time to time. If there is a material inconsistency between a definition of a term in this Section and the definition of that same term in an applicable section of the Ohio Revised Code, then that term will be interpreted by the definition in the applicable section of the Ohio Revised Code.
This section also is an index. Beside the definition will be Section numbers where You will see the term used.

Please call the AultCare Service Center if You have a question about what a term means or how it applies to You under the Policy.

ACCIDENT means an unforeseen injury caused by sudden, unexpected and sometimes violent means. See Section 30(E).

ACCIDENTAL BODILY INJURY means an injury occurring as a result of an accident, either directly or indirectly, along with all other related conditions You sustained while Covered under the Policy.

ADOPTED CHILD means a child that is properly placed, and that a court of competent jurisdiction has named You as the adoptive parent and awarded You with all legal rights and responsibilities for the Adopted Child, as if You were the natural parent. See Sections 4(B); 5(D)(1).

ADVERSE DETERMINATION means a determination by Us that an admission, availability of care, continued stay or other health care Service has been reviewed and, based upon the information provided, the health care Service does not meet the requirements for Benefit payment under the Plan and, therefore, is denied, reduced or terminated. See Sections 31(C)(2), (D)(2).

ALCOHOLISM means a primary, chronic disease, which includes symptoms such as craving, impaired control, increased tolerance and physical dependence on alcohol.

ALLOWABLE EXPENSE means the expense for Services that are Covered up to Maximum Allowable Charge. See Section 27(D).

AMBULANCE TRANSPORTATION means a professional, licensed ambulance company. It excludes private transportation. See Section 18(A).

ANNUAL DEDUCTIBLE means the amount of Eligible Expenses that You must pay each year before Benefits are paid. See Section 23(A).

ANNUAL MAXIMUM means the limit of Coverage during the Benefit Year that the Plan may pay. See Sections 18(F)(3), (K), (L).

APPEAL means Your right to have an Internal or External Review when there has been a denial of Your Claim for reasons including lack of Coverage, lack of Medical Necessity, or because the treatment is considered Experimental or Investigational. See Sections 1(G); 31(B); 32(B).

APPROVED REFERRAL means a referral, made by Your Network Provider in advance, that permits You to receive Services from a provider who is not a Network Provider. An Approved Referral does not guarantee payment of Your Claim at the highest level, or at all.

AULTCARE means AultCare Corporation and its affiliate McKinley Life Insurance Company.

AULTCARE ID CARD means the identification card that You are issued, which contains Your name, Your Group Number, Your ID number, the Effective Date of Coverage, the amount of Your Co-Payment responsibility and important telephone numbers You can call. Always show Your AultCare ID Card when You go to a Provider for Services. See Sections 4(C); 22(A), (B).

AULTCARE NETWORK means those Network Providers, listed in the AultCare Provider Directory, who provide medical and healthcare Services to Covered Persons under the Policy.

AULTCARE PROVIDER means any Hospital, Doctor, Podiatrist, Chiropractor, Psychologist or Allied Health Practitioner operating within the scope of his license with whom AultCare/McKinley has a contract for Services that generally are paid at a higher Benefit level. See Sections 3(B)(2); 15(E); 16(A); 24(A); 25(B)(1).

AULTCARE MEDICAL DIRECTOR means a physician who oversees the review of medical Claims and related issues for AultCare.

AULTCARE PROVIDER DIRECTORY means a periodic listing of physicians, hospitals and other providers that have contracts to be Participating Providers in the AultCare Network.

AULTCARE SERVICE CENTER means the office staffed by AultCare Representatives who are available to discuss questions with You about Coverage, rights and responsibilities and to assist You. See Sections 25(B)(2); 32(C); 33(A).

BENEFIT means Covered Charges for Covered Services You are entitled to receive under the Policy. See Section 5.

BENEFIT LEVEL OR LEVEL OF BENEFITS means the percent of Covered charges We will pay, depending on the type of Service and whether the Service was provided by a Network or a Non-Network Provider. See Sections 17(B)(2); 24(A)(1).

BENEFIT PERCENTAGE means the percent of Covered charges We will pay after You have paid the Deductible. See Section 27(B).

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

BENEFITS CHART (also known as Schedule of Benefits) means the information provided concerning the limits, maximums and specific details about Your Benefits Plan and Co-Payment amounts You must pay. See Sections 1(C); 3(A)(7).

BIOLOGICALLY BASED MENTAL ILLNESS means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychological Association.

BIRTHDAY RULE means a way to determine which health plan is Primary and which plan is Secondary under Coordination of Benefits based on the parent with the first birthday in a Calendar/Contract Year. The plan for the parent whose birthday is first is Primary for the children. See Section 28(E)(4).

BUSINESS DAY means normal hours of business, Monday through Friday, excluding holidays. See Section 22(A).

CALENDAR YEAR means a period of **12** consecutive months.

CASE MANAGER means a person who is assigned to help monitor and assist You when You are hospitalized or receiving other complex care. See Sections 1(F); 17(A).

CENTERS OF EXCELLENCE PROVIDER means an AultCare designated Non-AultCare Provider that meets quality and financial criteria that may be treated as panel. Pre-approval by AultCare Utilization Management is required for services to be paid at the panel level of benefit with no UCR.

CERTIFICATION (ALSO KNOWN AS PRE-APPROVAL) means a determination by our Utilization Management Department that an admission, availability of care, continued stay, or other health care Service has been reviewed and, based upon the information provided, the health care Service satisfies the requirements for Benefit payment under the Plan. See Sections 3(A)(6); 17(B)(2); 18(Q)(2); 24.

CERTIFIED HOME CARE AIDE means an individual, certified by the State of Ohio, and furnished through a Home Health Care Agency to provide Home Care Services, as prescribed, within the scope of his or her licensure. An immediate relative cannot act as a Home Care Aide.

CHILD (**CHILDREN**) means:

A. Any unmarried natural born child of Yours.
B. Any unmarried legally adopted child of Yours or child placed for adoption.
C. Any unmarried stepchild who lives with and is Dependent upon You for principal support.
D. Child does not include grandchildren.

CLAIM means a written request on an approved form for payment of Covered Services. See Section 25.

CLINICAL PEER means a physician or other practitioner who reviews medical records to determine whether a Service is Covered, according to accepted standards, including those for Experimental and Investigative treatment. See Sections 32(F), (G).

COINSURANCE means a percentage of medical expenses that You share with the Policy after you meet Your Annual Deductible. See Sections 15; 19.

COMPLAINT means a statement of disagreement when a Covered Person believes his or her rights may have been violated. A Complaint may be filed with AultCare or with the Ohio Department of Insurance. See Sections 3(B)(6); 32.

CONCURRENT REVIEW means utilization review conducted during the patient's hospital stay or course of treatment. See Section 24.

CONFINEMENT means You are admitted as an inpatient at a Hospital.

CONGENITAL DEFECT OR DEFORMITY means an imperfection, distortion or disfigurement of the body that is present at birth.

CONTRACT YEAR means a period of **12**-consecutive months as specified by the Policy. See Section 28(E)(4).

CONVALESCENT CARE means confinement in a Convalescent Facility, such as a nursing home.

COORDINATION OF BENEFITS means the procedure used to pay health care expenses when a person is covered by more than one plan. AultCare follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. This is to make sure the combined payments of all plans are no more than Your actual bills. See Section 28.

CO-PAYMENT means the dollar amount or percentage of costs shown in the Benefits Chart that a Covered person must pay directly to the provider for certain Covered Services (in addition to Premium). See Section 23.

COSMETIC SURGERY means surgery which is done to change the texture, shape or structure of any part of the human body considered normal, allowing for age and ethnic origin.

COST VARIANCE means the difference in cost between the discount rate agreed to by the Participating Network Pharmacies and what was actually charged by the Non-Participating Pharmacy. See Section 19(B)(1).

COURT ORDER means an official judgment or document, signed and issued by a Court of competent jurisdiction that is filed as a matter of public record. See 5(D)(2).

COVERAGE means You and Your Dependants are eligible to have AultCare pay Benefits for certain Services according to the Plan and subject to Deductibles, Co-Payments, Coinsurance, Exclusions and Maximums. See Section 5.

COVERAGE MONTH means that period of time beginning on the first of the month and ending on the day before the first of the next month in accordance with the effective date of Your Coverage.

COVERED PERSON means a person Eligible under the Plan to receive Coverage and Benefits. See Section 5(A).

COVERED SERVICES means the health Services and items described in this Certificate, and updated in the Benefits Chart, for which AultCare provides Benefits to Covered persons. See Sections 14; 18.

CREDITABLE COVERAGE means coverage of the individual under a group health plan, health insurance coverage, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a State health Benefits risk pool, a health plan offered under chapter 89 of title 5, United States Code, a public health plan as defined in regulations, a health benefit plan under section 5(e) of the Peace Corps Act, or other similar health care provision. However, a period of Creditable Coverage is not counted if there is a break in coverage of **63** calendar days or more (other than any applicable waiting period) between the end of the creditable coverage and the participant's or beneficiary's enrollment date under the new coverage. See Section 9(C).

CUSTODY means that you have the responsibility for the supervision or control of a minor or person who lacks capacity. See Section 28(E)(3).

CUSTODIAL CARE means Care given solely to assist a Person in the routine activities of housekeeping, bathing, eating and other activities of daily living.

DEDUCTIBLE means a specified dollar amount of medical expenses, which the Covered Person must pay before AultCare pays Benefits. See Section 23.

DENIAL means a determination by AultCare that a Claim will not be paid in full or in part for various reasons, including lack of Coverage, lack of Medical Necessity, or because the treatment is considered Experimental or Investigative. A Covered Person whose Claim has been denied has certain reconsideration, review and appeal rights. See Sections 3(B)(6); 32(B), (D), (E), (F), (G); 33(B), (C).

DEPENDENT means:

A. Your Spouse in a legal marriage recognized in the state of Ohio (Ohio does not recognize Common Law Marriage after 1991 or Civil Unions).

B. Your unmarried Child under the age of **19** years, if:

1. The Child is not eligible for Individual Coverage; and

2. The Child is not in the armed forces of any country; and

3. The Child depends on You for principal support.

C. Your unmarried Child under the Limiting Age if:

1. The Child is registered in and attending an accredited educational institution on a full-time basis as defined in the regulations of the institution; and

2. The Child depends on You for principal support.

   School vacation periods are considered a part of school attendance on a full-time basis.

D. Your unmarried Child who is incapable of self-sustaining employment as a result of mental retardation or physical handicap. The Child must have been incapacitated prior to reaching the Limiting Age and while insured as a Dependent under this policy. Extension of Coverage is subject to AultCare receiving written proof of the incapacity not later than **31** calendar days after the Child attains the Limiting Age. Proof of continued incapacity will be required not more than once each year.

DIAGNOSTIC SERVICES mean laboratory, radiological or other Services intended to diagnose Your medical condition. See Section 15(D).

DISABILITY means the inability to perform the material and substantial duties of Your job as the result of Accidental Bodily Injury or Sickness. Disability may be partial or total. Disability may be short term or long term. Disability may be temporary or permanent. See Sections 7.

DISCHARGE means the release from Hospital Confinement. See Sections 18(I)(2), (P)(1)(b).

DIVORCE DECREE means a court order, signed by a judge, which finalizes the divorce and which provides for the custody and responsibility for minor Children, including (without limitation) the responsibility for providing health insurance. See Sections 8(I); 10(B)(3), (D)(3).

DOCTOR means a qualified, licensed Doctor of medicine or osteopathy, and any other licensed health care provider that state law requires be recognized as a doctor practicing within the scope of his/her license. This does not include the Person (You), Your Dependent, or member of Your immediate family.

DURABLE MEDICAL EQUIPMENT means medical equipment and/or supplies that is furnished by a licensed supplier, which a Doctor orders as being Medically Necessary for You to use in the home for medical purposes, including improving function of a malformed body member. See Sections 1(G); 18(E).

ELECTIVE SURGERY means surgery that is not required to treat an emergency and which could be postponed or not done at all, without danger to the patient. Elective Surgery may require Pre-Approval or a Second Surgical Opinion. Check Your Benefits Chart.

ELIGIBLE DEPENDENT means Your Spouse or natural or dependent Children who meet certain requirements in order to participate as a Covered Person under the Policy and receive Benefits. See Sections 1(A), (B); 6; 7(A), (B); 8(E), (G).

ELIGIBLE EXPENSES mean those expenses for Covered Benefits that may be paid under the Policy after You meet Your Deductible, Co-Payment and any Co-Insurance requirements and subject to Maximum Allowable Charges. See also Allowable Expense. See Sections 14(B), (C); 27(A).

ELIGIBILITY means established requirements that a person must meet in order to participate as a Covered Person under the Policy and receive Benefits. See Sections 5; 10(A)(2); 11(A).

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

A. 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.

B. Serious impairment to bodily functions.

C. Serious dysfunction of any bodily organ or part.

EMERGENCY HEALTH SERVICES means those health care Services that must be available on a seven-days-per-week, 24-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such Services were not received as soon as possible. This includes, where appropriate, provisions for transportation and indemnity payments or Service agreements for out-of-area coverage. Emergency Services also include:

A. A medical screening examination, as required by federal law, that is within the capabilities of the emergency department of a hospital, including ancillary Services routinely available to the emergency department, to evaluate an emergency medical condition.
B. Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

ENROLLEE (MEMBER) means the policyholder named on the Policy issued by McKinley Life Insurance Company. See Section 9(B)(4)(d).

ENROLLMENT FORM means the specified form an Eligible Person needs to complete in a timely manner during Enrollment Periods in order to sign up for Coverage for You and Your Dependents. See Section 10(B)(2).

EXCLUSION means a procedure, condition or Service that AultCare does not Cover or pay Benefits. Exclusions appear in this document and in the Benefits Chart. See Sections 3(A)(7); 9(B)(4); 15; 20.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

EXPEDITED REVIEW means a review conducted quickly because of a Terminal Condition. See Sections 32(B)(4); 32(F); 34.

EXPERIMENTAL OR INVESTIGATIVE means Services, supplies, care, and treatment that do not constitute accepted medical practice, are inconsistent with relevant guidelines and/or government oversight agency guidelines and regulations at the time the Services were rendered. Experimental or Investigational includes (but is not limited to) the following. See Section 18(Q); 32(B)(3), (D)(3), (G); 33(C).

A. Any drug or device which cannot be marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device was furnished. (Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use).

B. Any drug, device, medical treatment, or procedure, or the patient informed consent document for the same, which is subject to review and approval by the treating facility's Institutional Review Board or other body serving a similar function, or which is required by federal law to such review or procedure.

C. Any drug, device, treatment, or therapy that is the subject of ongoing phase I or phase II clinical trials, or is the research, experimental study, or investigational arm of ongoing phase III clinical trials (with the exception of services relating to Routine Patient Care). Any drug, device, treatment, or therapy that is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared to standard means of treatment or diagnosis.

D. Any drug, device, treatment, or therapy which, according to the prevailing opinion of experts, requires further studies or clinical trials (with the exception of services relating to Routine Patient Care). to determine it maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared to standard means of treatment or diagnosis.

AultCare will make an independent evaluation to decide if a specific technology is experimental. This decision will be made in good faith following a detailed investigation of the Claim and the proposed treatment, and will be guided by a reasonable interpretation of the Policy.

EXPLANATION OF BENEFITS (EOB) means a statement that details Your Claim, including the Services provided, the amounts paid and Your payment responsibility. See Section 29.

EXTERNAL REVIEW means a review conducted by an Independent Review Organization. See Section 33.

FACILITY or HEALTH CARE FACILITY means a Hospital, clinic or ambulatory center that is licensed and/or accredited to provide health and medical Services to patients.

FAMILY (DEPENDENT) COVERAGE means Coverage for the Enrollee and for the Eligible Dependents, including Spouse and Dependent Children. See Sections 10(C)(3).

FEDERALLY ELIGIBLE means an individual who meets the following conditions: See Section 5(B).

A. The individual has at least **18** months of Creditable Coverage as of the date on which the individual seeks Coverage under this part.

B. The individual's most recent prior Creditable Coverage was under a group health plan, governmental plan, or church plan (or health insurance Coverage offered in connection with any of these plans).

C. The individual is not eligible for Coverage under any of the following:

1. A group health plan.

2. Part A or Part B of Medicare (Title XVIII of the Social Security Act).

3. A State plan under Medicaid (Title XIX of the Social Security Act) or any successor program.

D. The individual does not have other health insurance Coverage.

E. The individual's most recent Coverage was not terminated because of non-payment of Premiums or because of Fraud.

F. If the individual has been offered the option of continuing Coverage under a COBRA continuation provision or a similar State program, the individual has both elected and exhausted the continuation Coverage.

FRAUD means the intentional action by an applicant or Enrollee (Member) to defraud or knowingly mislead by providing false or deceptive statements. See Section 2; 17(B).

FULL-TIME STUDENT generally means a student between the ages of 19 and the Limiting Age who attends an accredited college, university, or formal post-secondary education program and who is enrolled in a number of courses or credit hours that the schools considers to be full-time. See Your Benefits Chart for details. See Section 6.

GUARDIAN means a qualified person, formally appointed by a court, which issues an order naming the guardian responsible for the care, custody, or support of a minor or person who lacks the mental capacity to care for himself (known as the ward). See Section 5(D)(4).

GENERIC DRUG means any legend drug dispersed as a less expensive substitute for the prescribed drug.

HEALTH SERVICES means the health care Services and supplies Covered under the Policy, except to the extent that such health care Services and supplies are limited or excluded under the Policy. See Sections 15(H)(1); 18(L).

HIPAA means the Health Insurance Portability and Accountability Act. HIPAA's Privacy Rule assures that Health Care Providers and Group Health Plans safeguard the proper use and disclosure of Your Protected Health Information. No Authorization is needed for Health Care Providers and Group Health Plans to share Protected Health Information for Treatment, Payment and HealthCare Operations. The Portability section of

HIPAA assures the transferability of health care coverage and protects against discrimination based on certain Pre-Existing Conditions. See Sections 3(B)(5); 26.

HIPAA AUTHORIZATION means a written consent, signed by the patient or claimant, that allows Us to disclose Protected Health Information to another for a specific purpose.

HOME CARE (HOME HEALTHCARE) means care that is provided to You for recuperation instead of regular Hospital Confinement. Home Health Care does not include care for progressive, debilitating conditions unless skilled nursing Services will render an improvement in Your condition or is a temporary need. See Section 18(F).

HOME HEALTHCARE AGENCY means an institution licensed and operated for the purpose of providing skilled nursing care to You in Your home.

HOSPITAL means a legally operated institution which:

A. Provides diagnosis, treatment and medical care of injured and sick individuals on an inpatient basis.

B. Has a staff of one or more doctors available at all times.

C. Provides **24** hour nursing Service.

D. Is not, other than incidentally, a convalescent facility or a place for aged individuals.

An institution accredited by the Joint Commission of Accreditation of Hospitals (or any successor organization) as a Hospital meets the requirements of this definition.

HOSPICE means a facility that:

A. Is licensed, accredited or approved by the proper authority to provide a Hospice Care Program.

B. Admits individuals who:

1. Have no reasonable prospect of a cure.

2. Have a life expectancy of **6** months or less.

3. Provides care by a Hospice Team coordinating its Services with the patient's Doctor and the family of the patient.

HOSPICE CARE PROGRAM means a coordinated program for meeting the special needs of dying individuals and their families. The program provides Palliative and supportive medical, nursing and other health Services through home, inpatient or outpatient care during the illness and bereavement. See Section 18(G)(1)(c), (G)(3)(h).

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

INCURRED DATE means the date treatment and Services are rendered.

INDEPENDENT REVIEW ORGANIZATION means a person or entity that conducts an External Review when a Claim has been denied. See Sections 32(E); 33(A), (B), (D); 34(B).

INDIVIDUAL COVERAGE means healthcare Coverage only for the individual Enrollee and not for the Enrollee's Eligible Dependents. See Section 10(A).

INPATIENT SERVICES means treatment and Services that are rendered when the patient is confined to a Hospital.

INTENSIVE CARE means special Hospital care, including twenty-four (**24**) hour nursing Service, for the treatment of severely or critically injured or sick patients.

INTENTIONAL MISREPRESENTATION means the providing of false or misleading information with the intent to defraud. See Section 17(B).

INTERNAL REVIEW means a review conducted by AultCare when a Covered Person requests a review because a Claim has been denied. See Sections 32(F); 33(E), (F).

INTERNAL REVENUE SERVICE DEPENDENCY GUIDELINES mean those criteria the IRS uses to determine whether a person qualifies and may be claimed as a dependent under the federal Tax Code. The IRS lists 5 tests for determining a dependent: (1) Member of Household or Relationship Test; (2) Citizen or Resident Test; (3) Joint Return Test; (4) Gross Income Test; and (5) Support Test.

The IRS defines a full-time student as a person who is enrolled for the number of hours or courses the school considers to be full-time attendance. The IRS defines school to include junior and senior high schools, colleges, universities, technical, trade and mechanical schools. The IRS excludes from the definition of school on-the-job training courses, correspondence schools and night schools. See Section 7(B)(1)

LICENSED PRACTICAL NURSE means a nurse who is licensed by the Nursing Board of the State of Ohio and is able to perform nursing duties consistent with that license. See Sections 18(F)(1)(c), (F)(2)(a).

LIFETIME MAXIMUM means the limit of Benefits a Covered Person may receive for certain designated Services of that Covered Person's lifetime. See Sections 15(H)(2); 27(D).

LIMITATIONS/EXCLUSIONS means care, Services or supplies that are not eligible for Coverage and payment of Benefits. These are listed in this document and in the Benefits Chart. See Section 20.

LIMITING AGE means the age in which a person no longer is eligible as a Dependent. The Limiting Age may differ, depending on the Plan. For Dependent Children who are not Full-Time Students or who do not have a Disability, the Limiting Age generally is 19. For Full-Time Students, the Limiting Age may be under **24**. Check Your Benefits Chart. See Sections 6; 7(A)(1).

LONG TERM ACUTE CARE or LTAC means an independent and separately licensed and accredited "hospital-within-a hospital" that provides specialized acute care to medically complex patients who require intensive Hospital Services for an extended recovery period.

MAINTENANCE CARE means care which administered after the patient has reached the maximum level of recovery. The purpose of Maintenance Care is to maintain the patient's current state of health. See Section 18(C).

MASTECTOMY means the surgical removal of the entire breast, usually to treat serious breast disease, such as breast cancer. See Section 18(O).

MAXIMUM ALLOWABLE CHARGE means the amount billed for Covered Services for which Benefits are available under the contract.

McKINLEY LIFE INSURANCE COMPANY is an insurance company affiliated with, and a part of the AultCare family of health care plans. See Section 1(A).

MEDICAL EMERGENCY means a condition with symptoms which appear life-threatening or disabling and requires immediate medical attention and treatment.

MEDICALLY NECESSARY means Services or supplies provided by a Hospital, Doctor or other provider to identify or treat an illness or injury, when those Services or supplies are determined to be: See Sections 18(F)(2); 32(F); 33(B).

A. Consistent with the symptom or diagnosis and treatment of the condition, disease, ailment or injury.

B. Appropriate with regard to the standards of good medical practice.

C. Not primarily for the convenience of the patient, the doctor or other provider.

D. The most appropriate supplies or Services that can be provided safely to the patient. For inpatients, it means that the patient's symptoms or condition requires that the Services or supplies cannot be provided safely on an outpatient basis.

MEDICARE means a federal insurance program administered by the U.S. Social Security Administration that provides medical and health benefits to qualifying individuals over the age of 65. See Sections 9(C)(1); 10(B); 24(C).

MONETARY PENALTY means an administrative penalty that results when You do not follow Our rules, such as when You need to obtain a Second Surgical Opinion for certain surgeries. See 21(A)(4)(b).

NECESSARY INFORMATION means face-to-face clinical evaluations, medical notes, or second opinions that may be required for conducting prospective reviews, certifications and making determinations. See Section 31(A).

NETWORK PROVIDER means a provider that has a contract to participate in an AultCare Network or Network that contracts with AultCare. The term Network Provider includes AultCare Providers.

NEWBORN CHILD means Your natural child Dependent born on or after the effective date of Your insurance. Newborn Child does not include grandchildren.

NON-COVERED SERVICES means treatment and Services that are not Covered or Eligible for payment of Benefits. The patient may be financially responsible for paying for Non-Covered Services. See Section 20(B).

NON-NETWORK PROVIDERS means those Doctors and licensed health care providers who do not have contracts with AultCare and who are not part of the AultCare Provider Network. See Section 1(D); 18(P)(2); 24(B).

NON-PARTICIPATING PROVIDER means a physician or other healthcare practitioner who has not signed a contract with AultCare.

NURSE means a graduate nurse other than You, Your Dependent or member of the immediate family. Nurse includes registered nurses and licensed practical nurses. See Section 3(A)(2); 18(M); 21(B).

OCCUPATIONAL THERAPIST means a licensed health professional who evaluates the self care and performance skills of persons who have disabilities with the intent of restoring the ability to perform daily tasks.

OFFICE VISITS mean receiving medical or healthcare Services in a Provider's private office. See Section 15(A), (C); 25(B).

OHIO DEPARTMENT OF INSURANCE is a regulatory agency of the State of Ohio that is responsible for regulating insurance. See Sections 28(E)(5); 32(C), (E).

ORTHOTICS means foot devices that do more than support the feet. They must restore function. To be Covered, Orthotics must meet the same requirements as Durable Medical Equipment. See Section 18(J).

OUT-OF-POCKET EXPENSES mean that portion of a bill or Claim that You are required to pay. An example of an Out-of-Pocket expense is the Co-Payment You must make when You receive Services at a Physician Office Visit. Your Co-Payment Out-of-Pocket Expense is listed in Your Benefits Chart and appears on Your AultCare ID Card. See Section 13(B)(1).

OUTPATIENT SERVICES means diagnostic testing, treatment and procedures when the patient does not need to be confined overnight. See Section 15.

PALLIATIVE means care that is not therapeutic or intended to cure, but instead is given to relieve pain and provide comfort for a patient in a Terminal Condition. See section 18(G)(2)(b), (G)(3)(c).

PHI means Protected Health Information, which includes personally identifiable information related to past, present and future medical or mental condition, treatment for that medical or mental condition, and payment for

treatment of that medical or mental condition. HIPAA requires Health Care Providers and Group Health Plans to safeguard the confidentiality of PHI.

PHYSICIAN means a doctor of medicine, or doctor of osteopathic medicine, or podiatric physician who is licensed by the Medical Board of the State of Ohio. See Sections 15(A); 18(B).

PLAN means a health benefit plan of insurance that offers health coverage and Benefits. The Policy is the Plan between You and McKinley Life Insurance Company.

PLAN YEAR may be a Calendar Year or a Contract Year. It is a period of **12** consecutive months in which Coverage is offered, which also may determine Your obligation for Deductibles and Annual Maximums. See Section 8(C).

PODIATRIST means a doctor of podiatric medicine who is licensed by the Medical Board of the State of Ohio. See Section 18(K).

POLICY means the insurance policy between the Enrollee and McKinley Life Insurance Company, which is affiliated with AultCare. See Section 5(A).

PRE-APPROVAL (PRE-AUTHORIZATION OR PRE-CERTIFICATION) means the process of notification prior to an Elective Hospital stay or Elective Surgery or procedure, to aid in determining that all medical care possibilities have been explored and are within acceptable time elements. The fact that a Hospital stay, surgery or procedure is Pre-Approved, does not mean that Benefits will be Covered and paid at the highest level, or at all. See Sections 3(A)(6); 13(B)(2); 15(E); 16(A), (B)(3); 18(Q)(2); 21.

PRE-AUTHORIZATION—See PRE-APPROVAL.

PRE-CERTIFICATION—See PRE-APPROVAL.

PRE-EXISTING CONDITION means a medical condition (physical or mental) for which You or Your Dependent were treated during the **6** months before You or Your Dependent Enrolled for Coverage under this Policy. See Section 9(B). Also see the HIPAA Portability Section that follows this Definitions Section.

PREMIUM means a regular payment that We establish to pay for Coverage under the Policy. See Sections 10(C)(3); 11(D); 12(A).

PRESCRIPTION TRADEMARK DRUG means any Brand Name medicinal substance, the level of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription."

PRESCRIPTION GENERIC DRUG means any legend drug dispersed as a less expensive substitute for the prescribed drug.

PREVENTIVE HEALTH SERVICES mean medical and health services that are concerned with preventing illness and disease, which may include physical examinations, certain screenings, diagnostic procedures, vaccinations and Well-Child Services. See Section 18(L).

PRIMARY PLAN or PAYOR means the health care plan that first must pay Claims when Benefits are being coordinated under Coordination of Benefits. See Sections 28(A), (C).

PRIVATE-DUTY NURSE means skilled nursing care ordered by a physician that is provided to an individual. See Section 18(M).

PROSPECTIVE REVIEW DETERMINATION means a determination by our Utilization Management Department that is conducted before admission or the beginning of a course of treatment. See Section 36(C).

PROSTHETIC DEVICE means a replacement, corrective, or supportive device, including repair and replacement parts for the device, worn on or in the human body to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body. See Section 18(N).

PROVIDER means a licensed physician or other health care provider who furnishes medical or health care services that may be Covered under the Policy. Also see Network Provider and Non-Network Provider. See Section 13; 25(B).

PROVIDER DIRECTORY means the listing of available Network Providers including (but not limited to) doctors, chiropractors, therapists, laboratories, medical equipment suppliers, hospitals, nursing Services and dentists.

QUALIFIED MEDICAL CHILD SUPPORT ORDER means a formal ordered issued in or after divorce proceedings that may create or specifically recognize the right of a child to be covered under the Plan. See Section 5(C)(2), (D)(3).

RECONSIDERATION means that process in which We will review a Denial of Approval or payment on a Claim, which will result in a determination whether to affirm, modify or change that Denial. See Section 31(A); 33(A).

RECONSTRUCTIVE SURGERY means surgery performed on abnormal structures of the body caused by defect, injury, or disease for the purpose of improving function or to approximate normal appearance. It is different from, and does not include, cosmetic surgery. See Section 18(O).

REFERRAL means that a Doctor has recommends or directs You to see another Doctor, who is often a specialist. The fact that a Network Provider makes a referral, even if it is Pre-Approved, does not guarantee that the Referral will be paid at the highest Benefit Level, or at all. See Sections 1(G); 13(B)(2); 21(A)(1).

REGISTERED NURSE means a nurse licensed by the State Nursing Board of Ohio. See Sections 18(F)(1)(c), (F)(2)(a), (G)(2)(b).

RESPIRATORY THERAPIST means a licensed healthcare professional, who provides respiratory care services to individuals with disorders and diseases to the cardiopulmonary system.

RETROSPECTIVE REVIEW means utilization review of Medical Necessity that is conducted after health care Services have been provided to the patient. See Section 31(E).

SCHEDULE OF BENEFITS is another name for BENEFITS CHART (See definition of BENEFITS CHART).

SECOND OPINION (**SECOND SURGICAL OPINION**) means an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for proposed health care Services to assess the clinical necessity and appropriateness of the proposed health care Service. See Section 3(A)(6); 21.

SECONDARY PLAN or PAYOR means the health care plan that may have responsibility to pay Claims after the Primary Care Plan pays in a Coordination of Benefits situation. See Sections 28(A), (D).

SEMI-PRIVATE means the most common Semi-Private room rate at the Hospital. See Section 16(A)(1).

SICKNESS means illness, bodily disorder or disease and mental infirmity. The following conditions also are considered as Sicknesses:

A. Alcoholism.

B. Drug addiction.

C. Pregnancy, complications of pregnancy, miscarriage and non-elective abortion. Complication of pregnancy means concurrent disease or abnormal conditions which affect in a major way the usual medical management of pregnancy.

SKILLED NURSING FACILITY is a facility which mainly provides inpatient skilled nursing and related Services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Doctors. A Skilled Nursing Facility is not, other than incidentally, a place that provides: (A) Minimal Custodial, ambulatory, or part-time care, or (B) Treatment for mental illness, alcohol/substance abuse, pulmonary tuberculosis. See Section 18(P).

SPEECH THERAPIST means someone who:

A. Has a Master's Degree in speech pathology.

B. Is licensed by the state in which he/she practices.

SPOUSE means husband or wife in a legal marriage recognized in the State of Ohio. For purposes of this Certificate, Spouse does not include, or apply to, common law marriages entered into after 1991. See Sections 5(C); 8(G); 10(D)(3);26; 28.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

STEPCHILD means a child of the Spouse's previous marriage or union who has not been legally adopted by You. See Section 10(B)(3).

SUBROGATION means that process when AultCare has paid Benefits on Your behalf but has a legal right to recover from the person, plan, program or insurance that is legally responsible for paying. See Section 35.

TERMINAL CONDITION means an irreversible, incurable, and untreatable condition caused by disease, illness or injury from which, to a reasonable degree of medical certainty, there can be no recovery and death is likely to occur within a relatively short time. See Sections 18(G)(1)(a); 33(C).

THERAPEUTIC means Services intended to treat an injury, disease or pathological condition. Therapeutic Services must be Medically Necessary.

THERAPY SERVICES means the following prescribed medical Services performed in or out of the hospital when such expenses are necessary for the diagnosis/treatment of a condition due to disease or illness.

A. Radiation and Chemotherapy - Benefits are provided for care/treatment in connection with chemotherapy, x-ray, radium or cobalt therapy.

B. Physical, Occupational, Respiratory, and Speech Therapy - Benefits are payable for care/treatment provided that the:

1. Care is rendered by a licensed therapist acting within the scope of their license.

2. Treatment is prescribed in writing by a licensed doctor.

3. Treatment is post-operative or for the convalescent stage or an active illness or injury.

4. Treatment is to restore function lost as a result of an illness/injury (accidental).

5. Treatment is necessary as a result of an acute illness or injury for rehabilitation purposes (speech therapy only).

C. Renal Dialysis - Benefits are provided for care or treatment in connection with renal dialysis.

TOTAL DISABILITY and TOTALLY DISABLED means:

A. With respect to You, the first 365 period, or the period covered under the Policy if less, the inability to perform the material and substantial duties of Your occupation as a result of Accidental Bodily Injury or Sickness. After the initial 365 day period, Total Disability means Your inability to perform the material and substantial duties of any occupation for which You are qualified by education, training or experience; and.

B. With respect to Your Dependent, the inability to perform the usual and customary duties or activities of an individual in good health and of the same age and sex.

TRIGGERING EVENT means the occurrence of an event that requires You to notify Us because of a change in Eligibility, Coverage, or other circumstances that may affect Coverage and Benefits. See Sections 8(G); 10(B)(1), (D)(1).

URGENT CARE SERVICES means those health care Services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person. This may include such health care Services provided out of the approved Service area pursuant to indemnity payments or Service agreements. See Section 17.

USUAL, CUSTOMARY AND REASONABLE (UCR) CHARGES means fees for Covered Services. For Network Providers, UCR may mean fees negotiated in their Provider contract. For Non-Network Providers, UCR means the representative or average and prevailing charge for the same health Service in the geographic community. AultCare uses software from an independent party to calculate UCR for Non-Network Providers, based on certain Medicare and other values used to calculate the average and prevailing charge. AultCare will not pay non-participating provider fees that exceed UCR. See Section 22.

UTILIZATION MANAGEMENT OR REVIEW means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care Services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. See Section.

WELL CHILD CARE means child health supervision services that cover the periodic review of a child's physical and emotional status performed in accordance with the recommendations of the American Academy of Pediatrics. Review includes a history, complete physical examination, developmental assessment, anticipatory guidance, newborn or infant hearing screenings, appropriate immunizations and laboratory tests.

WORKERS' COMPENSATION means a program administered by the State of Ohio to compensate persons who are injured in the course of employment.

YOU means the Enrollee and his or her Eligible Dependents.

GENERAL PROVISIONS

ENTIRE POLICY

This Policy, the Enrollment Application and any riders or endorsements to the above, shall constitute the entire Policy of coverage between parties. All statements made by an Enrollee shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce coverage under this Policy or be used in defense to a claim unless it is contained in a written application.

CHANGES

No alteration of this Policy and waiver of any of its provisions shall be valid unless evidenced by an endorsement or an amendment attached to this Policy which is signed by an executive officer of AultCare. No agent has authority to change this Policy or to waive any of its provisions.

GRACE PERIOD

This Policy has a 31 day Grace Period. This means that if any required Premium is not paid in full, on or before the date it is due, it may be paid during the Grace Period. During such period, the Policy stays in force.

If any required payment on Your behalf is not made during the Grace Period, your rights shall terminate as of the last date before which Premiums have been paid. Coverage may be reinstated only by renewed application and re-Enrollment in accordance with all requirements of this Policy.

REINSTATEMENT

If Coverage under this Policy lapses because the Premium has not been paid within the time allowed, this Coverage may be reinstated if the Plan accepts the Premium.

TIME LIMIT ON CERTAIN DEFENSES

No statement, except a fraudulent misstatement, made by a Member shall be used to void this Policy after it has been in force for a period of two years.

NOTICE OF CLAIM

Written notice of Claim must be given within 30 days after the date of loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice may be given at Our address shown on the Policy cover. Notice should include Your name and the name(s) of Your Dependent(s) and Your Policy number.

CLAIM FORMS

Upon receipt of notice of Claim, We will send You the forms for filing proof of loss. If the forms are not sent to You within 15 days, You will have met the proof of loss requirement by sending Us a written statement of the nature and extent of the loss within the time limit stated in the "Proof of Loss" subsection of this Policy.

***Benefits Not Listed are Not Covered. If You have a question about Your Benefits, please call the AultCare Service Center (330) 363-6360 or 1-800-344-8858.**

PROOF OF LOSS

You must give written proof of loss within 90 days after the date of loss. Your Claim will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written notice must be given within one year after the date proof of loss is otherwise required, except if You were legally incapacitated.

TIME OF PAYMENT OF CLAIMS

Subject to time period requirements under state law, payments due under the Policy will be paid immediately upon receipt of written proof of loss.

PAYMENT OF CLAIMS

We may pay all or a portion of any Benefits provided for Health Services to the Provider unless You direct otherwise in writing by the time proofs of loss are filed. We do not require that a particular Provider render the services.

Benefits accrued on behalf of You or Your covered Dependent upon death will be paid, at Our option, to any one or more of the following:

1. Your spouse;
2. Your Dependent children, including legally adopted children;
3. Your parents;
4. Your brothers and sisters; or
5. Your estate.

We will rely upon an affidavit to determine benefit payment, unless We receive written notice of valid claim before payment is made. The affidavit will release Us from further liability. Any payment made by Us in good faith will fully discharge Us to the extent of such payment.

PHYSICAL EXAMINATION AND AUTOPSY

We, at Our expense, have the right to have You examined as often as reasonably necessary while a Claim is pending. We may also have an autopsy made unless prohibited by law.

LEGAL ACTIONS

You cannot bring an action at law or equity to recover a claim until 60 days after the date written proof of loss is made. You cannot bring such action three years after such proof of loss is made.

CLERICAL ERROR

Clerical error shall not deprive any individual of coverage under this Policy. Neither shall failure to report the termination of any coverage, continue such coverage beyond the date it is scheduled to terminate according to

the terms of this Policy. Upon discovery of any clerical error, an equitable adjustment of monthly premiums shall be made.

WORKER'S COMPENSATION

The Benefits under this Policy are not designed to duplicate any benefit for which Covered Persons are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for Services provided to Covered Persons shall be reimbursed by, or on behalf of, the Covered Person to the Plan to the extent the Plan has made or makes payment for such Services. It is understood that Coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

MEDICARE

Any Benefits Covered under this Policy and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Policy provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under the Policy for Covered Persons age 65 and older, or Covered Persons otherwise eligible for Medicare, do not duplicate any benefit for which Covered Persons are entitled under Medicare, including Part B. Where Medicare is the responsible payor, all sums payable by Medicare for Services provided to Covered Persons shall be reimbursed by or on behalf of the Covered Persons to the Plan, to the extent the Plan has made payment for such Services.

CONFORMITY WITH STATUTES

Any provisions of this Policy, which on its effective date, is in conflict with the statutes of the jurisdiction in which it is delivered, is hereby amended to conform to the minimum requirements of such statutes.