AultCare Insurance Company
Canton, Ohio

Certificate of Coverage and Benefits

This Certificate explains the basics of Your Health Care Coverage, Benefits and duties under the Master Group Policy. Your Benefits Chart, which is a part of this Certificate, 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 Certificate 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 for members outside Stark County at 1-800-344-8858 to talk to the AultCare Service Center, or visit our website at www.aultcare.com. You also may write Us at:

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

TABLE OF CONTENTS

SECTION 1 – BASIC INFORMATION AT A GLANCE 4
SECTION 2 – FRAUD WARNING 8
SECTION 3 – ENROLLEE RIGHTS AND RESPONSIBILITIES 8
SECTION 4 – LET YOUR EMPLOYER KNOW WHEN YOUR RECORDS NEED TO BE UPDATED 9
SECTION 5 – ELIGIBILITY FOR COVERAGE AND BENEFITS 10
SECTION 6 – SPECIAL CIRCUMSTANCES FOR A CHILD WITH A DISABILITY 11
SECTION 7 – ENROLLMENT 12
SECTION 8 – COVERAGE FOR EMPLOYEES 14
SECTION 9 – COVERAGE FOR DEPENDENTS 16
SECTION 10 – EVENTS THAT CAN AFFECT ELIGIBILITY, COVERAGE AND BENEFITS 18
SECTION 11 – INDIVIDUAL REINSTATEMENTS 20
SECTION 12 – COBRA 21
SECTION 13 – CONTINUATION UNDER OHIO LAW 23
SECTION 14 – GUARANTEED RENEWABILITY 23
SECTION 15 – USING NETWORK PROVIDERS 24
SECTION 16 – COVERED SERVICES (BENEFITS) 25
SECTION 17 – COVERED OUTPATIENT SERVICES 26
SECTION 18 – COVERED INPATIENT HOSPITAL AND REHABILITATIVE SERVICES 32
SECTION 19 – EMERGENCY AND URGENT CARE SERVICES 33
SECTION 20 – OTHER COVERED SERVICES 35
SECTION 21 – MANAGED PRESCRIPTION DRUG PROGRAM 52
SECTION 22 – EXCLUSIONS/NON-COVERED SERVICES 60
SECTION 23 – USING YOUR AULTCARE CARD 68
SECTION 24 – YOUR RESPONSIBILITY FOR COPAYMENTS, DEDUCTIBLES, COINSURANCE 69
SECTION 25 – REFERENCE BASED PRICING (“RBP”) 69
SECTION 26 – FILING YOUR CLAIM 70
SECTION 27 – YOUR HIPAA PRIVACY RIGHTS 71
SECTION 28 – COORDINATION OF THIS CONTRACT’S BENEFITS WITH OTHER BENEFITS 71
SECTION 29 – EXPLANATION OF BENEFITS (“EOB”) 77
SECTION 30 – SUBROGATION, REIMBURSEMENT AND OTHER INSURANCE 78
SECTION 31 – DETERMINATION TIME FRAMES 80
SECTION 32 – QUESTIONS, COMPLAINTS, REVIEW AND APPEALS 81
SECTION 33 – EXTERNAL REVIEW 85

SECTION 34 – EXPEDITED REVIEW **87**
SECTION 35 – OTHER RIGHTS YOU MAY HAVE **88**
SECTION 36 – DEFINITIONS **89**
SECTION 37 – HIPAA PORTABILITY **106**
SECTION 38 – RESPONSIBILITIES AND RIGHTS UNDER ERISA AND OTHER FEDERAL LAW (IF APPLICABLE) **107**
SECTION 39 – MISCELLANEOUS **116**
..... **117**
SECTION 40 – IMPORTANT TELEPHONE NUMBERS AND ADDRESSES **117**
SECTION 41-OHIO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION NOTICE **118**

Section 1 – Basic Information at a Glance

Thank You for choosing AultCare Insurance Company.

A. Who We Are

Your Coverage and Benefits are through a Master Group Policy between Your Employer and AultCare Insurance Company. AultCare Insurance Company has a contract with its affiliate, AultCare Corporation, to provide Services. AultCare Insurance Company may do business as "AultCare." Your ID card may read "AultCare Insurance Company" or "AultCare".

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

We will use "You" to mean You as the Employee and Your Eligible Dependents who are Covered under the Master Group Policy between AultCare Insurance Company and Your Employer.

We will use "Employer" to mean Your Employer, who is the Policyholder of the Master Group Policy.

B. Why You Are Receiving this Certificate

Your Employer has a Master Group Policy with AultCare Insurance Company to provide health Coverage and Benefits to You and Your Eligible Dependents.

This Certificate summarizes Your Coverage and Benefits under the Master Group Policy. It is **NOT** an insurance policy or insurance contract with You. It does not alter the Coverage, Benefits, or terms of the Master Group Policy.

Keep this Certificate in a safe place. Your Employer may give You a Summary Plan Description. In some cases, this Certificate may act as the Summary Plan Description.

C. Using this Certificate and Benefits Chart

This Certificate explains the basics of Your Coverage and Benefits under the Master Group Policy. Your Benefits Chart, which is a part of this Certificate, 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. The Benefits Chart is not an insurance policy or insurance contract with You. Check both this Certificate and Your Benefits Chart when You have questions.

D. Independent Medical Decisions

AultCare does not employ Network Providers. AultCare does not practice medicine. Your Doctor is an independent practitioner. AultCare does not tell Your Doctor how to practice medicine. AultCare does 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.

AultCare is 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 AultCare Insurance Company or AultCare for the negligence of Providers.

E. 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.

Written proof of loss or claims must be furnished to Us within 90 days after the termination of the period for which We are liable and in cases of claims for any other loss within 90 days after the date of loss.

Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within the appropriate timeframe, provided that documentation is provided as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

F. Assignment

Benefits payable under the Policy shall be paid, with or without assignment from You, to public Hospitals or clinics for services and supplies provided to You when a proper claim is submitted by the public Hospital or clinic. No Benefits shall be paid to the public Hospital or clinic if such Benefits have been paid to You prior to our receipt of the claim. Payment of Benefits to the public Hospital or clinic shall discharge Us from all liability to You to the extent of such Benefits.

No assignment of Benefits to any person or organization other than a public Hospital or clinic is binding unless filed with Us.

AultCare does not release any plan governing documents to third parties (i.e. providers, legal representatives, etc.) unless requested through a court order.

G. Case Management Care Coordination

Utilization Management nurses and Care Coordination Nurses coordinate Your Inpatient and Outpatient Medical or Behavioral Health/Substance Abuse/Opioid Abuse care with Providers. These teams 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.

H. Utilization Management

Certain Services, such as admissions, Referrals, Home Health Care Services, Skilled Nursing Facility Services, and Durable Medical Equipment, and genetic testing need Pre-Approval by the Utilization Management Department. Please note that this is not an exhaustive list of services that require Pre-Approval. For a complete list, please contact the AultCare Service Center.

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

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 health care, such as a Hospital stay, and a decision is made not to Cover all or part of Your stay, Coverage for Your Health Care will continue until You are notified of the decision. Benefits may stay the same for this period.

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

In situations which a decision is needed more quickly because of Your medical condition, UM will review the case as quickly as possible. We will promptly notify You in writing. If You are unhappy with UM's decision, You can Appeal. Please see Sections 32 and 33 for more detailed information regarding timeframes for review.

Our UM Department may require Pre-Approval, Concurrent Review and Second Surgical Opinions.

Pre-Approval

Pre-Approval (also called "Pre-Certification" or "Prior Authorization") is an evaluation of Your medical case by Your Provider and AultCare medical professionals to determine the appropriateness and Medical Necessity of the services requested. If You do not receive Pre-Approval and it is later determined by our UM Department that the service is not Medically Necessary, the claim will not be paid. It 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. You will not be penalized if Pre-Approval is not obtained for care from a Network Provider, but it is needed to help determine if other appropriate medical care possibilities have been explored and are within acceptable time elements. Charges that exceed the Reference Based Pricing allowance, also called "RBP," are not covered. Please refer to section 16 for details on Non-Network Cost Share. 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. Pre-Approval is not required for treatment of Emergency Medical Conditions.

1. You need to be Pre-Approved when:

    a. You are admitted to any Facility.

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

    c. You need Durable Medical Equipment with a purchase price of $2,500 or greater.

    d. Your Physician ordered genetic testing.

    e. You are receiving certain Diagnostic Services

f. For admission to a Network or Non-Network Inpatient Residential Treatment Facility.

g. Certain surgical procedures

h. Your Physician orders or You are receiving care that requires a prior assessment to determine if the service or treatment meets clinical requirements for medical necessity, appropriateness, level of care, or effectiveness.

This list of services that need to be Pre-Approved may be revised by AultCare from time to time. For a complete list of services requiring Pre-Approval, please contact AultCare at 330-363-6360 or 1-800-344-8858.

1. How to Request Pre-Approval:

   a. Network Providers may call the UM Department for You and request Pre-Approval.

   b. Visit the AultCare website at www.AultCare.com to access the electronic Prior Authorization portal.

   c. If You use a Non-Network Provider, You may need to call the UM Department to request Pre-Approval before You receive Services.

   d. You must be Pre-Approved within two Business Days from when You become a Hospital Inpatient.

2. You have a Right to:

   a. Receive basic information about which drugs and services will require Pre-Approval.

   b. Receive Pre-Approval for medications used to treat chronic diseases under certain circumstances up to a 12-month period or until the last day of eligibility under Your policy or plan, whichever is lesser.

Concurrent Review

Our UM nurse will work directly with providers at each level of care. Coordination includes, but is not limited to, member outreach from a Case Manager, or one-one-one health coaching. Concurrent Review is completed by AultCare Nurses in the UM Department when:

1. You are in the Hospital.

2. You have ongoing behavioral health or substance abuse treatment.

3. You have Home Health Care/Skilled Nursing Facility Services.

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

Definitions

Some terms in this Certificate have special meaning. Capitalized terms are defined in the Definitions Section. If You do not know what a term means, call Us at 330-363-6360 or 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 Us via our website at **www.aultcare.com**, or call Us at the Fraud hotline **800-204-5119, or 330-363-2887**, or write Us at:

AultCare
P.O. Box 6910
Canton, Ohio 44706

Section 3 – Enrollee Rights and Responsibilities

Quality Health Care and Benefits are responsibilities You share with Your Doctors and Your Plan. We want You to know Your responsibilities and rights. They are based on common sense, courtesy, and honest communication. If You have a question, concern, or a recommendation for how AultCare could improve its policies for promoting Enrollee responsibilities and rights, contact Us via our website at www.aultcare.com.

You have a Right to:

- Receive information about the organization, its Services, its practitioners and Providers, and Member rights and responsibilities.
- Receive information about Your Coverage and Services.
- A list of Doctors, Hospitals, and other Network Providers. See our website, www.aultcare.com.
- Be treated with dignity and respect.
- A frank discussion with Your Doctor about Your medical condition, including appropriate and Medically Necessary treatment options, regardless of cost or Benefit Coverage and to participate in making decisions about Your Health Care. Your Doctors are independent. They are not restricted or prohibited from discussing treatment options with You, including those that are not covered.
- Privacy of Your Health Care and Claims information. Your Protected Health Information will be used to pay Claims, as permitted by HIPAA and as described in Your Notice of Privacy Practices. Protected Health Information will not be disclosed to others without Your authorization, except as permitted by HIPAA and state law.

- Ask questions, raise concerns, make Complaints, and Appeal Denials as explained in Your Certificate or Benefits booklet.

- To make recommendations about AultCare's Member Rights and Responsibilities Policy.

- Request accommodation if You have limited knowledge of the English language.

You have a Responsibility to:

- Take Your AultCare ID card when You go to the Doctor, Hospital, drug store, or Health Care Provider. It contains important information. Having Your card may help save time and prevent mistakes.

- Tell the Doctor or Nurse about Your condition. Tell Your Doctor what medications You are taking. Answer any questions the Doctor or Nurse may ask You completely and truthfully. This information may help Your Doctor form treatment goals and alternatives. Understand Your health problems and participate in developing mutually agreed-upon goals.

- Ask questions if You do not understand something about Your medical condition and the treatment alternatives (including medications) the Doctor is recommending.

- Follow Your Doctor's medical advice and instructions. Take medications as directed. Let the Doctor know if You have a bad reaction. Let Your Doctor know if Your symptoms do not get better, or if they get worse. Schedule recommended follow-up appointments.

- Live a healthy lifestyle.

- Be an informed Enrollee by checking Your Benefits Chart.

- Let Your Employer know if there are changes with You and Your Dependents.

- Get all required Pre-Approvals (Pre-Certification).

- Call AultCare if You have questions about Your Coverage or responsibilities.

Section 4 – Let Your Employer Know When Your Records Need To Be Updated

A. Keeping Your Records Up to Date is IMPORTANT

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

B. Updating Records

Tell Your Employer within 31 calendar days if there are changes in Your name, address, phone number, or marital status, or if there are changes with Your Dependents, such as when You have a Newborn or Adopted Child.

The Coverage for newly born children shall consist of Coverage from birth through the 31st day of life and shall include necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If the addition of a child requires additional premium, AultCare may require payment of the required premium be paid within thirty-one days after the date of birth in order to have the coverage continue beyond such period.

You need to Tell AultCare about any changes to Your Coverage, including Coverage and Benefits You or Your Dependents may have from other insurance.

If You applied for individual coverage, You can change to family coverage if You marry or add a dependent. Failure to report any change in family status within thirty-one (31) days of change may result in Non-coverage.

The date coverage is effective for a spouse or Child depends upon when We are notified. It is very important that Members keep Us informed of their family status. If there is a change in either the number of Dependents or the identity of a Dependent because of birth, death, marriage, divorce, adoption or any reason, We must be informed immediately. It is possible that claims for family members may be denied if they are not properly reported as Dependents.

C. Using Your Current AultCare Card

It is important that You use Your current AultCare 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 card or if Your Coverage or Benefits change.

Section 5 – Eligibility for Coverage and Benefits

A. Eligibility

Eligibility means that an Employee or Dependent meets the requirements to enroll as a Covered Person in the Certificate and receive Coverage and Benefits.

B. Employee Eligibility

You are Eligible if:

1. You work a normal workweek of 30 or more hours. "Eligible Employee" does not include a temporary or substitute Employee, or a seasonal Employee who works only part of the calendar year on the basis of natural or suitable times or circumstances.

2. You meet Your Employer's Eligibility policies.

3. You meet Your Employer's Waiting Period (not to exceed 90 days).

C. Eligibility of Your Spouse as a Dependent

Your Spouse may be Eligible as a Dependent if You are legally married.

D. Eligibility of Children as Dependents

Your Children are Eligible as Dependents if the Child is:

1. Your natural-born or legally Adopted Child or a Child Placed with You for adoption.

2. Your Stepchild.

3. Named in a Qualified Medical Child Support Order and is otherwise Eligible for Coverage. We will enroll for immediate Coverage under this Policy any dependent who is the subject of a Medical Child Support Order that is not already covered by this Policy as an Eligible Dependent once We determine that such order meets the standards for qualification under Section 609 of the Employee Retirement Income Security Act.

4. A Child for whom the court has named You Guardian.

5. A Child for whom a court has named You having Legal Custody.

6. A Child for whom You are required to provide health insurance by court or administrative order.

7. A child who has not yet reached the end of the month in which they turn 26.

Coverage is available to Your Dependent Child without regard to whether the Child is married or unmarried.

E. No Genetic Screening

Eligibility for Coverage is not subject to Genetic Testing or any results of Genetic Testing.

F. Tell Your Employer When a Dependent No Longer is Eligible

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

Section 6 – Special Circumstances for a Child with a Disability

A Child may continue as an Eligible Dependent if:

1. The Child is incapacitated while insured as a Dependent by AultCare, or by another Health Care Plan, before the end of the month in which that Child turns 26; and

2. The Child is incapable of self-sustaining employment by reason of an intellectual disability or physical handicap; and

3. The Child is primarily dependent upon the policyholder for support and maintenance; and

4. You give proof of incapacity. We may request proof once every 2 years.

Section 7 – Enrollment

A. Enrollment

Enrollment means You and Your Dependents may sign up for Coverage and Benefits under Your Employer's Master Group Policy.

B. Initial Enrollment

Initial Enrollment is when a new Employee must complete an Enrollment Application. Some Plans permit You to complete Initial Enrollment within 31 calendar days from the date You are hired. Other Plans permit Initial Enrollment on the first day after the Employee completes a Waiting Period (not to exceed 90 days).

C. Open Enrollment

Employers have Open Enrollment Periods (at a minimum 30 consecutive days) when Eligible Employees are given the option to:

1. Pick a different Health Care Plan.

2. Add or drop Health Care Coverage.

3. Add or drop Dependents.

If You choose not to enroll Yourself or Your eligible dependents during Your Employer's Open Enrollment period or within 31 days following the date of any event that qualifies for special enrollment, You must wait until the next annual Open Enrollment period.

D. Special Enrollment

Special Enrollment is when an Eligible Employee, who did not enroll in the Plan when Eligible or during Open Enrollment, may enroll because of special circumstances. Unless specifically stated otherwise You may enroll within 31 days from the date of a triggering event.

Triggering events include:

1. An eligible individual or Dependent loses minimum essential Coverage;

2. An eligible individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption; or

3. If a QHP applies, an eligible individual who was not previously a citizen, national, or lawfully present, unintentional enrollment or non-enrollment in a Qualified Health Plan (QHP), violation by QHP of a material contract provision, new eligibility determination, access to a new QHP through a permanent move, Native Americans may change one time per month, other exceptional circumstances as the Exchange may provide.

Loss of minimum essential Coverage refers to:

1. Loss of eligibility for Coverage (Coverage is not COBRA Continuation Coverage);

2. Loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;

3. Loss of Coverage because You no longer live in the service area;

4. Loss of Coverage because plan no longer offers any benefits to the class of similarly situated individuals;

5. Termination of employer contributions;

6. Exhaustion of COBRA Continuation Coverage.

Loss of minimum essential Coverage does not include failure to pay premiums on a timely basis or situations allowing for a rescission.

E. Rescission

Rescission is permitted only if the insured (or person acting on their behalf) does any of the following:

1. Commits fraud; or

2. Makes an intentional misrepresentation of material fact.

Insurers must provide at least 30 calendar days' notice before rescinding coverage.

Insureds have the right to request both internal and external appeals.

F. Dependent Special Enrollment

Dependent Special Enrollment is a 31-calendar-day period when an Eligible Dependent of an Employee 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 previously had not been Eligible to enroll during Open Enrollment, or the Dependent did not enroll because of other Coverage, which that Dependent no longer has. If You are required by court or administrative order to provide Coverage to a Child, the Child must be enrolled in this Plan without any enrollment period restrictions.

G. How to Enroll

To enroll for Coverage and Benefits under the Master Group Policy, You must complete an Enrollment Application in a timely manner.

H. How to Add a Dependent

To add an Eligible Dependent, see Your Employer 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.

I. How to Drop a Dependent

To drop a Dependent, see Your Employer as soon as possible.

J. When You need to Update Enrollment Information

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 26 years old, unless the Dependent Child is disabled.

See Your Employer as soon as possible to update, change or end Coverage for Yourself or for a Dependent.

Section 8 – Coverage for Employees

A. When Coverage Begins

1. Each Employee in an eligible class on the date the Master Group Policy takes effect will be eligible for Coverage on that date. Each Employee who enters such class after this date may be eligible for Coverage on the first day after he or she completes the Waiting Period (not to exceed 90 days).

2. If You or Your Dependents are in an eligible class, but are absent from work on the date Coverage is to begin because You are in the Hospital or Your absence is for health reasons, You will be considered Actively at Work and eligible for Coverage to begin. Coordination of Benefits will apply if You have other Coverage.

B. Your Coverage Ends

Your coverage cannot be terminated except for the following approved reasons:

1. The Employee is no longer eligible for group coverage;

2. The Employee changes from one plan to another during open or special enrollment; or

3. The Employee commits fraud or makes an intentional material misrepresentation.

Your Coverage will end at the earliest of:

1. The date Coverage ends for everyone under the terms of Your Employer's Master Group Policy;

2. The end of the period for which the last Premium has been paid for You;

3. The date Your Employer's Master Group Policy ends;

4. The end of the period for which You made the last contribution;

5. The last day of the Coverage Month of the date employment ends except as stated in the COBRA Continuation of Coverage Rights Section;

6. The last day of the Coverage Month in which You request termination, but not prior to the date of the request;

7. The last day of the Coverage Month in which You retire;

8. The last day of the Coverage Month of the date employment ends for which You enter active military service for any country, except for temporary duty of 30 days or less, or when a reservist is ordered to active duty, as provided by Ohio law;

9. The last day of the Coverage Month in which You cease to be Actively At Work, except if You cease to be Actively At Work due to Sickness or Accidental Bodily Injury, Hospitalization Coverage will continue until the earliest of the following:

    a. The last day of the Coverage Month for which the last contribution is made;

    b. Inpatient care is no longer Medically Necessary;

    c. Discharge from the Hospital for episode of care;

    d. The Benefit Limit under the Master Group Policy has been reached; or

    e. Coverage by another carrier begins.

10. The employee is no longer eligible for group coverage;

11. The employee changes from one plan to another during open or special enrollment; or

12. The employee's coverage is rescinded for a non-prohibited reason.

Check with Your Employer as to when Your Coverage Terminates based on Your circumstances and for options that are available to You for additional Coverage under Federal and Ohio law.

C. Failure to pay Premiums

The Grace Period between Your Employer and Us is 31 days from when a premium payment is due in full. Your Employer must pay premiums in accordance with due dates in order to keep this policy in force and effect.

Section 9 – Coverage for Dependents

A. Date Your Dependents are Eligible for Coverage

Your Dependents will be Eligible for Coverage the later of:

1. The date You are Eligible for Employee's Coverage; or

2. The date You gain a Dependent.

B. To Add a Dependent

1. To add a Dependent, tell Your Employer within 31 calendar days of the Triggering Event, such as marriage, birth, adoption or Placement for Adoption. If You fail to do so, You must wait for Open Enrollment.

2. Fill out the Enrollment Form if You are adding a newborn, an Adopted Child, a Child placed for adoption or a Child for whom You are required to provide health insurance Coverage by court or administrative order. Include the Dependent Child's name, social security number (if available), date of birth (or other Triggering Event) and Coordination of Benefits information. If a 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, give it to Your Employer.

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.

C. Date Dependent Coverage Takes Effect

1. If Coverage is Noncontributory, it will become Effective for Your Dependent on the day the Dependent becomes Eligible and Coverage becomes Effective. You must enroll eligible Dependents in order for Your Dependents to be Covered, unless Your Employer has specifically provided otherwise.

2. If Dependent Coverage is Contributory, it will become Effective after You apply for Dependent Coverage on the Enrollment Form and agree in writing to pay the required Contributions for Your Dependent, and on the date Your Dependent becomes Eligible.

3. On the date of birth for a Child born after the Effective Date of Your Coverage. If Your Plan requires an additional premium payment to maintain coverage for the Child, You must notify Your Employer of the Birth and request Coverage for that Child within the 31-day period following the Child's birth in order to continue coverage after the initial 31-day coverage period.

4. On the date of adoption, Placement for Adoption, or court or administrative order to provide health insurance to a Child. Coverage will be effective for the first 31 days following adoption, Placement for Adoption or court or administrative order requiring You to provide health insurance to a Child. You must notify Your Employer of the adoption, Placement for Adoption, or court or administrative order within 31 calendar days following the date of such event in order to continue Coverage after 31 calendar days. You may need to pay an additional Premium.

D. Your Dependent's Coverage Ends the earliest of:

1. The last day of the Coverage Month in which Your Dependent no longer meets eligibility requirements;

2. The last day of the Coverage Month for which the last contribution is made;

3. The date the Master Group Policy is terminated;

4. Inpatient care is no longer Medically Necessary;

5. Discharge from the Hospital for episode of care; or

6. Coverage by another carrier begins.

E. To End Dependent Coverage

1. To end Coverage for a Dependent, tell Your Employer within 31 calendar days from the Triggering Event.

2. Your Employer will give You a form to remove the Dependent from Your Plan.

3. If Your Spouse 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.

4. If Your Child is ending Coverage as a Dependent because he or she reached the age of 26, tell Your Employer immediately.

F. Children's Health Insurance Program Reauthorization Act of 2009

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) permits You or Your dependent, if eligible but not enrolled in Coverage under Your Group Health Plan, to enroll if either of the following conditions is met:

1. You or Your dependent covered under Medicaid or the State Children's Health Insurance Program (CHIP) has Coverage terminated as a result of loss of eligibility, and You request Coverage for You or Your dependent within 60 days after termination; or

2. You or Your dependent becomes eligible for a subsidy (state assistance program) under Medicaid or CHIP, if You request Coverage within 60 days after the eligibility determination date.

Section 10 – Events that Can Affect Eligibility, Coverage and Benefits

A. Changing From Individual Coverage to Family Coverage

If You have Individual Coverage, and You have a triggering event, You may change to Family Coverage. The date Family Coverage becomes Effective for a Spouse or Child may depend on when You notify Your Employer. It is important that You tell Your Employer as soon as possible, but no later than 31 calendar days from the triggering event, about changing to Family Coverage. Failure to let Your Employer know within 31 calendar days may result in Non-Coverage or Denial of Claims.

B. Enrolling in Medicare

Tell Your Employer if You or a Dependent enrolls in Medicare. Your Coverage may no longer be Primary if You or Your Dependent enrolls in Medicare. Reference the 'Coordination of this Contract's Benefits with Other Benefits' section of this document.

C. Going on Disability

1. If You go on Disability, Your Eligibility and Coverage could be affected.

2. Disability means that You are unable to perform Your employment functions or work at Your Employer because of injury or Sickness for a period that Your Employer has set.

3. Check with Your Employer.

D. Temporary Layoff or Leave of Absence

If You temporarily stop being Actively at Work because of temporary layoff or approved leave of absence not subject to FMLA, Your Eligibility may be affected and Your Coverage may Terminate. Check with Your Employer as to when Your Coverage Terminates based on Your circumstances. When Coverage Terminates, You may be eligible for COBRA or Continuation Coverage.

Your Coverage will terminate on the earliest of:

1. The 90th day after You stop being Actively at Work;

2. The date Premium payments stop; or

3. The date stated in the Collective Bargaining agreement, if applicable to Your Employer sponsored Coverage.

E. Going on Family Leave

Family Medical Leave Act (also called "FMLA"), which allows You to take up to 12 work weeks of unpaid, job-protected leave a year, may apply to Your Employer. If FMLA applies and You go on an approved Family Leave, that leave could affect Your Eligibility and Coverage. Please check with Your Employer.

F. Going on Military Duty

1. USERRA

   If Coverage would terminate because You take a leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as modified by the Veterans' Benefits Improvement Act of 2004, Your Benefits may continue for the lesser of the period of leave or 24 months. Coverage may Continue only as long as You make the required Contributions. If You are on a USERRA leave for less than 31 calendar days, You must make the same Contribution as is required for active Employees. If You are on a USERRA leave for 31 calendar days or longer, You may be required to pay up to 102% of the full cost (Employee and Employer Contributions) of Coverage.

2. Ohio Law for Reservists Called or Ordered to Active Duty

   a. If You are a reservist who is called or ordered to active duty, Your Employer must notify You of the option to continue Coverage for up to 18 months after the date on which the Coverage otherwise would end because You are called or ordered to active duty. You may continue to receive Coverage for up to 18 months, so long as You or Your Employer pays the Premium.

   b. Coverage may be continued for up to 36 months if any of the following occur during that 18-month period:

      i. Death, divorce or separation of the reservist.

      ii. A reservist's Dependent Child ceases to meet Eligibility requirements.

   c. You must give Your Employer a written election to continue Coverage. You may be required to pay the Employer the first payment. Your Employer must receive the written election and payment no later than 31 calendar days after the date on which Your Coverage otherwise would end. You must continue to pay the monthly amount to keep Coverage. See Your Employer or call Us if You have any questions.

G. Retirement

Coverage ends when You voluntarily cease to work Full-Time for Your Employer.

H. Workers' Compensation

This Plan is not a Workers' Compensation policy and is not issued in lieu thereof. The benefits under this Certificate are not designed to duplicate benefits that Members are eligible for under the Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to a Member shall be paid back by, or on behalf of, the Member to the Plan if the Plan has made or makes payment for the services received. It is understood that coverage under this Certificate does not replace or affect any Workers' Compensation coverage requirements and this Certificate does not satisfy any requirements for Coverage by Workers' Compensation Insurance.

This plan does not cover:

1. Charges eligible for coverage under any Workers' Compensation Law or similar law.

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

3. Charges for You, Your Dependents, or Spouse for a work related injury or illness while self-employed if eligible to obtain coverage under any Workers' Compensation Act or similar law.

If Workers' Compensation Benefits are not available to You, this limitation does not apply.

Section 11 – Individual Reinstatements

If Your Coverage ends because You are laid off or Discharged, it may be Reinstated if You return to work Full-Time. The following apply:

A. If Your return occurs within 14 calendar days from the date of layoff, which is the day You lose Coverage, there will be no break in Coverage. Your Coverage is contingent upon working a normal workweek of 30 or more hours.

B. If Your return occurs more than 14 calendar days after the date of layoff, which is the day You lose Coverage, You may be considered a new Employee, and the Coverage for Employees Section may apply.

C. You may need to pay a Premium before You can be Reinstated.

D. Benefits Reinstated will not exceed the Maximum Benefits that would have been available if You or Your Dependents had been continuously Covered without a Termination Date or interruption.

Check with Your Employer if You have questions about Reinstatement.

Section 12 – COBRA

A. COBRA Continuation of Benefits

If Your Employer has 20 or more Employees and the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 applies, certain events will permit You or Your Dependents to choose to continue Coverage with AultCare by paying monthly Premiums. You may choose to continue Coverage in the following situations:

1. Termination of employment (except for gross misconduct) or reduction of hours of employment.

2. Employee death.

3. Divorce of Covered Employee.

4. A Dependent Child reaches the Limiting Age for Coverage.

5. Bankruptcy of Employer.

6. The Covered Employee becomes eligible for Medicare.

B. Continuing Period

1. If Your employment is terminated or Your hours are reduced, You may choose to continue Coverage for up to 18 months. In the case of a divorce, legal separation, or death of the Employee, You may elect to continue Coverage for up to 36 months.

2. If You or the person who seeks to continue Coverage under COBRA is Totally Disabled for Social Security purposes, the 18-month period may be extended to 29 months. To receive the additional 11 months of Coverage, Social Security must have determined that You or Your Eligible Dependent were Totally Disabled within the first 60 calendar days of COBRA Coverage. You must notify Your Employer within 60 calendar days of the date of Termination. These maximum extension periods may be offset by any other period extension.

3. If You are on COBRA because of Termination of employment or a reduction in hours, and a divorce, legal separation or death occurs, You may be able to elect an additional 36 months of Coverage.

C. End of COBRA Coverage

COBRA Coverage will end before the end of this maximum period for any of the following reasons:

1. Failure to pay applicable Premiums for the Coverage within the allowable grace period.

2. The former Spouse or Dependent Child becomes entitled to Benefits under the Social Security Act.

3. The Employee or Dependent is Covered under any other Group Health Plan. AultCare Coverage ends when the new Coverage begins.

4. The Employee or Dependent is entitled to Medicare Benefits.

5. A former Spouse remarries and is Covered under another group Plan.

6. Termination of the Master Group Policy between AultCare and Your Employer.

EXCEPTIONS: There are three (3) exceptions:

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

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

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

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

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

D. Choosing COBRA Coverage

In the case of Employee Termination, reduction in hours, or death, Your Employer will notify You and Your Dependents of Your COBRA options.

In the case of divorce or if Dependent ceases to be Eligible, You must notify Your Employer within 60 calendar days of that event. Failure to do so may make You ineligible for continued Coverage. Upon timely receipt of the information, Your Employer will notify You or Your Dependents of COBRA options.

Section 13 – Continuation Under Ohio Law

Ohio law requires Employers with fewer than 20 Employees to give involuntarily terminated Employees the option of continuing their group medical Coverage for up to 12 months. You may be eligible to continue AultCare Coverage for You and Your Covered Dependents for up to 12 months after Termination, so long as You pay the Premium. Continuation Coverage may not exclude prescription drug Coverage if it is included in the group Coverage. You must meet all of the following requirements:

A. You have been continuously insured under a group policy or under the policy and any prior similar group coverage replaced by this policy during the three-month period before Termination of Your employment.

B. You must have been involuntarily terminated, other than for gross misconduct.

C. You are neither eligible for, nor covered by, Medicare.

D. You are neither eligible for, nor covered by, any other insured or uninsured arrangement that provides Hospital, surgical or medical Coverage for individuals in a group.

Section 14 – Guaranteed Renewability

Your Employer may renew its Master Group Policy for all Eligible Employees and Dependents. There are exceptions. We may choose not to renew the Master Group Policy or to discontinue health Coverage for one or more of the following reasons:

A. Your Employer failed to pay Premiums.

B. Your Employer commits Fraud or Intentionally Misrepresents a Material Fact under the terms of Coverage.

C. The Master Group Policy is terminated.

D. Violation of participation or contribution rules.

E. Discontinuation of Plan

F. Market exit.

G. Association membership cease

Guarantee issue coverage is provided to small employers that enroll during open enrollment regardless of any minimum participation or employer contribution requirements.

Section 15 – Using Network Providers

A. Services from Network Providers

1. The Level of Benefits You receive under the Master Group 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 Provider Directory, which is on Our website at www.aultcare.com.

3. If Your provider is terminated without cause and You are currently in active treatment, We may continue to allow payment at the Network level of Benefits with this provider until Your active treatment is complete or for 90 days, whichever is shorter. Additionally, We define active course of treatment as meaning:

   a. An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

   b. An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

   c. The second or third trimester of pregnancy, through the postpartum period; or

   d. An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

B. Services from Non-Network Providers

1. When You choose a Non-Network Provider, You may not receive the same Level of Benefits. Charges that exceed the Reference Based Pricing allowance, also called "RBP," are not covered. You may need to pay more Out-of-Pocket Expenses.

2. There may be certain services that can only be obtained from a Non-Network Provider. In order for You to avoid the Non-Network Cost Share, such as Deductible and Out-of-Pocket, You must obtain approval in advance from AultCare. Upon AultCare's prior approval of the Non-Network care, benefits for Covered Services will be paid according to the In-Network benefit as if the Covered Services were provided by a Network Provider. Charges over RBP will be Your responsibility. This is also referred to as Balance Billing. Please reference Section 25 for information on RBP.

   Updated treatment plans will be required periodically to determine if care can be transitioned to a Network provider. We may require that Your care be transitioned to a Network provider if it is determined that in Network providers are available.

AultCare will determine whether the Covered Services can be provided by a Network Provider, and that determination will be final and conclusive, subject to any available appeals process. If You do not receive written approval in advance of receiving Covered Services from a Non-Network Provider, services will be covered at the Non-Network provider level and You will be subject to balance billing and increased out-of-pocket expenses. Services provided to You in an Emergency Medical Condition will be covered at the Network level of benefit, although You may be balanced billed for Non-Network Emergency Services.

3. Certain Services by an AultCare approved Non-Network Centers of Excellence Provider will be Covered at the same level as a Network Provider if such Services are not offered by Network Providers. Pre-Approval is required for these Services to be Covered at Network level, in which RBP may not apply. Services provided by a Non-Network Center of Excellence will still be subject to appropriate Coinsurance, Copays, and Deductibles. Charges over RBP will also be Your responsibility This is also referred to as Balance Billing. Please reference Section 25 for information on RBP.

C. Emergencies or When You are Out of Town

The Plan will cover Services for an Emergency Medical Condition treated in any Hospital Emergency department or Urgent Care Center. Plans will not require Prior Authorization or impose any other administrative requirements or Benefit Limitations that are more restrictive than Emergency Services received from a Network Provider. If You seek Emergency Services from a Non-Network Provider, You may be billed for charges that exceed the RBP allowance. This is called balance billing.

D. Emergencies When You are Traveling Outside of the USA

Generally, We may pay for limited Emergency Services that are necessary when You are traveling outside of the USA, unless You are expressly traveling on business on behalf of Your Employer. 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 16 – Covered Services (Benefits)

A. General Description of Covered Services (Benefits)

Covered Services are medical and health Benefits that You and Your Eligible Dependents may receive under the Master Group Policy.

B. Questions about Benefits and Eligible Expenses

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

Section 17 – Covered Outpatient Services

For certain Covered Services and depending on Your Plan design, You may be required to pay a part of the Maximum Allowed Amount as Your Cost Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Outpatient Services may include:

A. Physician Office/Home Visits

Office Visits to Your Physician for treatment of illness or injury.

This may include injectable drugs and other drugs administered in a Physician's office or other Outpatient setting, or Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in Your home.

B. Gynecology Office/Home Visits/Sterilization/Infertility

Office Visits to Your gynecologist for Medically Necessary examinations. Sterilizations are also a covered service.

Charges for Impotency, Infertility, and Reversal of Sterilization are **Not Covered** under this Plan. This includes:

1. Drugs used for erectile dysfunction.

2. Pregnancy of a surrogate mother unless surrogate is a Member covered under the plan.

3. Treatment of any kind related to infertility, for means of conception, including drugs administered in connection with these procedures, unless specifically stated in Your Benefits Chart.

4. Artificial Insemination and In Vitro Fertilization are not covered.

5. Reversal of voluntary sterilizations.

6. Elective abortion is excluded. Therapeutic abortion is covered, which is an abortion performed to save the life or health of the mother, or as a result of incest or rape.

C. Office/Home Visits to Medical and Surgical Specialists

Necessary and appropriate Office Visits to medical and surgical specialists. Home Visits for medical care and consultations to examine, diagnose, and treat and illness or injury.

D. Other Practitioner Office/Home Visits (Nurse, Physician Assistant)

Office Visits to another licensed practitioner for treatment of illness or injury. Home Visits for medical care and consultations to examine, diagnose, and treat and illness or injury.

E. Telemedicine

Telemedicine services means a mode of providing health care services through synchronous or asynchronous information and communication technology by a health care professional, including interactive audio, video and other electronic media, within the professional's scope of practice, who is located at a site other than the site where the recipient is located. This includes online clinic visits.

The Plan will not exclude from coverage a Telemedicine medical service, solely because the service is not provided through a face-to-face consultation.

The Plan will pay for a Telemedicine Health Care Service only if the service is a Covered Benefit under the Plan, is not excluded by the Plan, and all the following requirements are met:

1. The informed consent of the Covered Person, or another appropriate person with authority to make health care treatment decisions for the Covered Person, is obtained before Telemedicine health care services are provided;

2. The Participating Health Professional is licensed or has obtained a certificate to provide Telemedicine health care services in the appropriate state of jurisdiction;

3. The participating provider complies with minimal standards of care and all requirements set forth in rules and interpretive guidance adopted or issued by the State of Ohio (including the Ohio Medical Board) and/or the appropriate state of jurisdiction governing Telemedicine health care services and prescribing to persons not seen in person by a physician;

4. The services are provided by a Primary Care Provider or any Doctor of Medicine (M.D.), Doctor of Osteopathic Medicine (D.O.), who are licensed to practice medicine, osteopathic medicine or podiatric medicine, a licensed Behavioral Health Provider, a Physician Assistant, or an Advanced Practice Registered Nurse;

5. The service is for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Telemedicine services will be paid according to Your Plan with no greater Cost Share than if Services were rendered in a face-to-face setting.

Note: Subject to Network and Non-Network cost sharing. If You seek Telemedicine health care services from a Non-Network Provider, You may be billed for charges that exceed the Reference Based Pricing allowance.

F. Diagnostic Services

Diagnostic services are tests or procedures performed when You have specific symptoms, to detect or monitor Your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

• X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
• Magnetic Resonance Angiography (MRA).
• Magnetic Resonance Imaging (MRI).
• CAT scans.
• Laboratory and pathology services.
• Cardiographic, encephalographic, and radioisotope tests.
• Nuclear cardiology imaging studies.
• Ultrasound services.
• Allergy tests.
• Electrocardiograms (EKG).
• Electromyograms (EMG) except that surface EMG's are not Covered Services.
• Echocardiograms.
• Bone density studies.
• Positron emission tomography (PET scanning).
• Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
• Echographies.
• Doppler studies.
• Brainstem evoked potentials (BAER).
• Somatosensory evoked potentials (SSEP)
• Visual evoked potentials (VEP)
• Nerve conduction studies.
• Muscle testing.
• Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

G. Genetic Counseling and Testing

Genetic counseling is covered under Your Plan. Prior Authorization is required for all genetic testing, and is subject to Medical Necessity determinations.

H. Outpatient Surgery

Medically Necessary surgical procedures, anesthesia and Outpatient Facility fees are covered. Please contact Us to determine if Your procedure requires Prior Authorization

I. Therapy Services

Medically Necessary therapy services are covered when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. Therapy determined to be maintenance in nature is not covered.

Occupational Therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation;; soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

Physical Therapy including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.

Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

Speech Therapy for the correction of a speech impairment.

Manipulation Therapy/Chiropractic Services are used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system and neuromusculoskeletal disorders, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy Services. Manipulation Therapy Services rendered in the home as part of Home Care Services are not covered.

Chiropractic Services from a licensed Chiropractor when Services are Medically Necessary are covered. Care determined to be maintenance in nature is not covered.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and Services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: Admission to a Hospital mainly for physical therapy and long term rehabilitation in an Inpatient setting.

Day Rehabilitation Program Services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, two or more days a week at a Day Hospital. Day rehabilitation program Services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing Services, and neuro psychological Services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

J. Other Therapy Services

Additional Coverage includes therapies such as radiation therapy, chemotherapy, infusion therapy, renal/dialysis, hemodialysis, Pulmonary Rehabilitation, Cardiac Rehabilitation.

Pulmonary Rehabilitation to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory Services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Cardiac Rehabilitation to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered. Phase III is not covered.

Chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.

Dialysis treatments of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine.

Radiation Therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high-energy particle sources); materials and supplies used in therapy; treatment planning.

Inhalation Therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs

in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

K. Habilitative Services and Devices

Habilitative benefits will include, but shall not be limited to, services and devices for patients with a medical diagnosis of Autism Spectrum disorder, which at a minimum shall include the following Outpatient Services:

1. Outpatient Services include:

    a. Speech and Language therapy and/or Occupational therapy, performed by licensed therapists; and

    b. Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to Applied Behavioral Analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the Services in accordance with a treatment Plan**.**

    c. Mental/Behavioral Health Outpatient Services overseen by a licensed Psychologist, Psychiatrist, or Physician and implemented by licensed therapists, to provide consultation, assessment, development and oversight of treatment Plans.

L. Allergy Testing and Treatment

Appropriate allergy testing and treatment, including injections and serum.

M. Mental/Behavioral Health Services and Alcohol/Substance Abuse Services

Full parity is applied to all existing Mental/Behavioral Health and Substance Abuse Benefits beyond the Ohio Mental/Behavioral Health provisions, to allow for all Mental/Behavioral Health diagnoses/Services to be covered as equal to those Benefits for medical and surgical Services.

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

N. Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

Section 18 – Covered Inpatient Hospital and Rehabilitative Services

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

We will cover all Medically Necessary Inpatient Hospital Services. Network Providers may get Pre-Approval for You. You must make sure that Your Non-Network Provider gets Pre-Approval for You. Ongoing review of care while You are confined is required to determine Medical Necessity.

Inpatient Hospital Services may include:

1. Semi-Private room and board.

2. Doctors' Services or other Professional provided Services related to medical treatment or surgery.

3. General nursing Services.

4. Diagnostic Services, such as laboratory, X-ray, advanced diagnostic imaging (CT, PET Scans, MRIs), cardiographic, encephalographic, electromyographic, and endoscopic and organ exams.

5. Other therapies such as radiation therapy, chemotherapy, infusion therapy, renal/dialysis, and hemodialysis.

6. Operating room, anesthesia and supplies.

7. 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.

8. Prescribed drugs given while in the Hospital.

9. Services for human organ and tissue transplants.

10. Examination, Services, supplies, medication, procedures and surgeries that the medical profession considers to be unproven, Experimental or Investigational are not covered.

B. Inpatient Rehabilitative Services for Treatment of Physical Injury or Illness

We will Cover all Medically Necessary Inpatient Rehabilitative Services. Network Providers may get Pre-Approval for You. You must make sure that Your Non-Network Provider gets Pre-Approval for You.

Inpatient Rehabilitative Services may include:

1. Semi-Private room and board.

2. Doctors' Services or other professional provided Services related to medical treatment or surgery.

3. General nursing Services.

4. Diagnostic Services, such as laboratory, X-ray, advanced diagnostic imaging (CT, PET Scans, MRIs), cardiographic, encephalographic, electromyographic, and endoscopic and organ exams.

5. Other therapies such as physical, occupational, and speech therapy, radiation therapy, chemotherapy, infusion therapy, renal/dialysis, and hemodialysis.

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 Rehabilitative Facility.

When the patient does not require intensive therapy and fails to improve any further, Coverage will be discontinued, and the patient will transition to an appropriate level of care.

Physical Rehabilitation Facilities include Coverage for Day Rehabilitation Program Services subject to the visit limitation with Inpatient Services.

C. Inpatient Treatment for Mental/Behavioral Health and Alcohol/Substance Abuse

Behavioral Health Services also includes coverage for Biologically Based Mental Illness services. 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 Psychiatric Association.

Section 19 – Emergency and Urgent Care Services

A. Emergency Services

Emergency Services - A medical screening examination, as required by federal law, that is within the capability of the Emergency department of a Hospital, including ancillary Services, and any trauma and burn center, routinely available to the Emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient.

Stabilize means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person's medical condition is likely to result from or occur during a transfer, if the medical condition 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.

4. In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

The Plan will cover Services for an Emergency Medical Condition treated in any Hospital Emergency department. If applicable, Emergency Services will be Covered according to Your Benefits Chart no matter when or where You receive them. Plans will not require Prior Authorization or impose any other administrative requirements or benefit limitations that are more restrictive than Services received from a Network provider. If You seek Emergency Services from a Non-Network Provider, You may be billed for charges that exceed the Reference Based Pricing allowance. This is called balance billing.

We must cover Emergency Services without regard to whether a particular Health Care provider is a Network provider with respect to the Services and cannot impose any Cost Share that is greater than what would be imposed if Services were provided in Network. For example, We cannot require a $50 co-pay for a Network Emergency department visit and $200 co-pay for a Non-Network Emergency department visit.

Maximum allowable fee (the amount this Plan will pay the Provider) for a covered expense for Emergency Services provided by Non-Network providers in a Hospital's Emergency department is an amount equal to the greatest of:

1. The median fee negotiated with Network providers;

2. The fee calculated using the same method to determine payments for Non-Network Provider Services;

3. The fee paid by Medicare for the same 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.

In addition, if You contact Your Physician and are referred to a Hospital Emergency room, benefits will be provided at the level for Emergency Services. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week.

Emergency Services do not need to be Pre-Approved before You seek treatment. If You are admitted to a 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 two Business Days after receiving care, or as soon as You can. This will allow a Case Manager to follow Your care. AultCare's UM Department 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.

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 RBP if You receive Urgent Care treatment at a Non-Network Facility.

Section 20 – Other Covered Services

We generally may Cover the following Services:

A. Ambulance Transportation Services

Ambulance Transportation to the nearest Hospital in an Emergency by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick, injured, and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. Transportation must be by a licensed, professional Ambulance Service.

Coverage includes (Pre-Approval required for Non-Emergency services):

1. Ambulance transportation between hospitals.

2. Ambulance transportation between a hospital and a Skilled Nursing Facility.

3. Ambulance transportation from a Hospital or Skilled Nursing Facility to Your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when You are not transported will be covered if Medically Necessary.

Ambulance services are a Covered Service only when Medically Necessary, except:

1. When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or

2. When a Member is required by Us to move from a Non-Network Provider to a Network Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for Your condition. If none of these facilities are in Your local area, You are covered for trips to the closest facility outside Your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include but are not limited to, trips to:

1. A Physician's office or clinic;

2. A morgue or funeral home;

Other vehicles, which do not meet this definition, including but not limited to ambulettes, are not Covered Services.

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. Dental Services Covered Under Your Medical Plan

Certain Dental Services, such as treatment for injuries to natural teeth caused by an Accident, including the initial replacement of these injured teeth. Damage to Your teeth due to chewing or biting is not deemed to be an Accidental Injury and is not covered. Accidental Dental Services are subject to a $3,000 limit per injury. Dental Services resulting from an Accidental Injury when treatment is initiated within 12 months of the injury, or as reasonably soon thereafter as possible are covered under Your Plan. The benefit limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than the Physician performing the service, or to Services that We are required by law to cover. Covered services include, but are not limited to oral examinations, X-rays, tests and laboratory examinations, restorations, prosthetic Services, oral surgery, mandibular/maxillary reconstruction, and anesthesia.

For a Child requiring facial reconstruction due to a dental related injury, services are covered even if there are several years between the Accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- oral examinations
- x-rays
- tests and laboratory examinations
- restorations
- prosthetic services
- oral surgery
- mandibular/maxillary reconstruction
- anesthesia

Other covered dental Services include facility charges for Outpatient Services for the removal of teeth or for other dental processes if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient. X-rays, supplies, appliances, and all associated expenses for transplant preparation, initiation of immunosuppresives and direct treatment of acute traumatic injury, cancer or cleft palate

D. Durable Medical Equipment and Supplies

Durable Medical Equipment - The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e. could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home.

Examples include but are not limited to wheelchairs, crutches, Hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Rental or purchase of Durable Medical Equipment, including supplies, if:

- The equipment or supply is for Your use only;
- The equipment has a life up to 6 months;
- The equipment or supply is primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury;
- The equipment improves the function of a malformed body part or delays further deterioration of Your physical condition;
- The equipment or supply can effectively be used in a non-medical facility (Your home);

- The equipment or supply can be expected to contribute meaningfully to the treatment of the illness or injury;
- Your Doctor certifies that the equipment is Medically Necessary and UM determines that Medical Necessity guidelines are met.
- The equipment is furnished by a licensed DME supplier.

Covered items include, but are not limited to:

- Hemodialysis equipment;
- Crutches and replacement of pads and tips;
- Pressure machines;
- Infusion pump for IV fluids and medicine;
- Glucometer;
- Tracheotomy tube;
- Cardiac, neonatal and sleep apnea monitors;
- Insulin pump and continuous glucose monitor;
- Augmentive communication devices are covered when We approve based on the Member's condition.

Durable Medical Equipment Not Covered under Your Plan includes Charges for items for:

- Personal hygiene, environmental control or convenience;
- Exercise equipment;
- Repair and replacement of DME due to misuse, malicious breakage or gross neglect;
- Replacement of lost or stolen items;
- Medical and Surgical Supplies- Adhesive tape, band aids, cotton tipped applicators; arch supports; doughnut cushions; hot packs, ice bags; vitamins; medijectors; air conditioners; ice bags/cold pack pump; raised toilet seats; rental of equipment if the Member is in a Facility that is expected to provide such equipment; translift chairs; treadmill exerciser; tub chair used in shower.

Medical and Surgical Supplies - Certain supplies and equipment may be covered under the Prescription Drug benefit, if any. Syringes, needles, oxygen, surgical dressings, splints and other similar items, which serve only a medical purpose. Prescription Drugs and biologicals that cannot be self-administered are provided in a Physician's office. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

- allergy serum extracts
- chem strips, glucometer, lancets
- Clinitest
- needles/syringes
- ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non Covered Services include but are not limited to:

- adhesive tape, band aids, cotton tipped applicators
- arch supports
- doughnut cushions
- hot packs, ice bags
- vitamins
- Medi-Jectors

Orthotics

Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.
Covered orthotic devices may include, but are not limited to, the following:

- cervical collars.
- ankle foot orthosis.
- corsets (back and special surgical).
- splints (extremity).
- trusses and supports.
- slings.
- wristlets.
- built-up shoe.
- custom-made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.
Non-Covered Services include but are not limited to:

- Orthopedic shoes (except therapeutic shoes for diabetics).
- Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
- Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
- Garter belts or similar devices.

If You have any questions regarding whether a specific orthotic is covered, call the customer service number on the back of Your Identification Card.

Prosthetic Devices

Prosthetic Devices are artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes.

Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

- Replace all or part of a missing body part and its adjoining tissues;
- Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
- Left Ventricular Artificial Devices (LVAD)
- Breast prosthesis whether internal or external, following a mastectomy, and 4 surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply;
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc;
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session. Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lense(s) inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered;
- Cochlear implant;
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care;
- Restoration prosthesis (composite facial prosthesis);
- Wigs (the first one following cancer treatment, not to exceed one per Benefit Period);

Non-Covered Prosthetic appliances include but are not limited to:

- Dentures, replacing teeth or structures directly supporting teeth.
- Dental appliances.
- Such Non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
- Artificial heart implants.

- Wigs (except as described above following cancer treatment).
- Penile prosthesis in men suffering impotency resulting from disease or injury.

E. Home Care Services

Covered Services are those performed by a Home Health Care Agency or other Provider in Your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. A treatment plan will be required to determine medical necessity as determined by the Plan.

Covered Services include but are not limited to

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.
- Nutritional Guidance.
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy that will not be covered when rendered in the home). Home Care Visit limits specified in the Benefits Chart for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Approved Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing.
- Certain Home health care services may be approved at the discretion of AultCare when the patient is not confined to the home.

Non Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if You obtain Pre-Approval from AultCare (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home infusion therapy includes

but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Infusion therapy can be given in the hospital or in an outpatient setting as alternative sites of care. Review for medical necessity of select IV and injectable therapy services will include determination of the medical necessity of the appropriate Site of Care (location for Your infusion). Options may include homecare, an ambulatory infusion center, physician office, etc.

Preferred sites of care include:

- Physician's office
- Infusion Center
- Home

Non-preferred sites of care include:

- Hospital Outpatient setting

Non-hospital outpatient setting alternative sites of care are the preferred sites of care for medications addressed in this Certificate.

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

F. Hospice Care

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months. When approved by Your Physician, Covered Services include the following:

- All Covered Home health care services listed above, except nursing Services that may be approved for up to 8 hours in any 24-hour period.
- Palliative Services and supplies furnished by the Hospice team, including part-time nursing and Skilled Nursing care by, or under the supervision of, a Registered Nurse.
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment Plan.
- Prescription Drugs given by Hospice and Dietary guidance.
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment)
- Counseling Services
- Home health aide visits.

3. Hospice related exclusions include:

- Homemaker Services.
- Volunteer Services.

G. Maternity Services

1. Maternity Services include:

   - Hospital charges related to Your pregnancy.
   - Pre-natal and Post-natal care, including Inpatient care and follow-up care for a mother and newborn. Maternity related Services that are preventive under state and federal law are also covered.
   - Treatment for complications of pregnancy or Childbirth, and any obstetrical disorder, injury or condition arising from Childbirth.

2. Maternity Services do not include Services or supplies provided to a person not covered under the Certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

3. Hospital Admissions (Inpatient Care).

   Coverage includes a 48-hour Hospital admission for routine vaginal delivery and a 96-hour Hospital admission for routine caesarian section delivery. Services covered as Inpatient care shall include medical, educational, and any other Services that are consistent with the Inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. Please inform the UM Department 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 shall be provided for 72 hours after Discharge.

   Please notify the UM Department as soon as reasonably possible.

4. Post Delivery Care Visits

   Post Delivery Care may be provided at Your residence by a Physician or Nurse performed no later than 72 hours following You and Your Newborn Child's Discharge from the Hospital. Coverage includes but is not limited to: assessment of the parent and newborn; parent education; assistance and training in breast and bottle feeding; assessment of the home support system; clinical tests; other Services consistent with follow-up care recommended in the protocols and guidelines of national organizations representing pediatric, obstetric and nursing professions; and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your Newborn Child, including the collection of an adequate sample for the hereditary and metabolic Newborn screening.

   At Your discretion, this visit may occur at the Physician's office.

Newborns' and Mothers' Health Protection Act (NMHPA)

The Plan will not restrict Benefits for any Hospital length of stay in connection with Childbirth for the mother or Newborn Child, following a normal vaginal delivery, to less than 48 hours, or to less than 96 hours in the case of a Cesarean section. In addition, the Plan will not require a Hospital, Physician or other medical Provider to obtain authorization or Pre-Certification from the Employer or an insurer (if applicable) or their respective medical review specialist for prescribing any length of stay described above. However, these rules do not apply where the decision to Discharge the mother or her Newborn Child prior to the expiration of the minimum length of stay periods described above is made by the mother's or Child's attending Physician in consultation with the mother.

H. Podiatry Services

Podiatric Services ordered or rendered by Your Podiatrist are subject to Cost Share and Coverage Exclusions.

Routine foot care is not Covered and includes:

- Foot care to improve comfort or appearance, including care operations, and procedures for flat feet, subluxations, corns, bunions (except capsular and bone surgery) calluses and toenails.

- Surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, and hyperkeratosis.

I. Preventive Health Services

We will Cover Preventive Health Services and supplies ordered and provided by or under the direction of a Doctor in an appropriate Health Care setting. We also cover Child health supervision Services, meaning periodic review of a child's physical and emotional status performed by a physician, by a Health Care professional under the supervision of a physician, or, in the case of hearing screening, by an individual acting in accordance with Ohio law. Periodic review means a review performed in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests. Coverage also includes tests, screenings and Services, such as:

- Well-Child Care, including immunizations.

- Routine screening mammograms. We will cover the following screening mammograms in accordance with State and Federal law:

    - If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

    - If a woman is at least forty years of age but under fifty years of age, either of the following:

        - One screening mammography every two years;
        - If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.

- If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

The total benefit for a screening mammography under this Plan, regardless of the number of claims submitted by Providers is based on the Medicare reimbursement rate (not to exceed 130%) in the state of Ohio for a screening mammography. Non-Network Providers may not balance bill.

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

We Cover Preventive Health Services 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:

- Screening such as cholesterol.
- Blood pressure checks.
- Physicals.

We will also cover other recommended Preventive screenings, immunizations and services as required by federal law including nutritional counseling, if You receive services from a Network Provider. For an up-to-date list of other recommended Preventive services, check with the AultCare Service Center or visit www.Health care.gov.

Nutritional Counseling is covered for a total of four per calendar year visits for:

- Children 6 years and older; or
- Adults with a Body Mass Index of 30 or higher
- Adults who are obese and have additional cardiovascular risk factors

Preventive services must be prescribed by a licensed physician and provided by a registered dietitian, nutritionist, or other licensed professional trained in medical nutrition therapy.

We cover Preventive Health Services as defined in federal law without any cost sharing if You receive Services from a Network provider. You will be notified, at least 60 days in advance, if any item or service is removed from the preventive list of eligible Services. Eligible Services will be updated annually to include any new recommendations or guidelines.

Education and Training interventions must have an outcome expected to improve the outcome of the member's health care status. Educational interventions must be done by licensed professional staff.
Covered education includes but is not limited to: ostomy care, diabetic education, wound care, tracheostomy care.

Please call Customer Service at 330-363-6360 if You have questions regarding Preventive Services for Nutritional Counseling or for Medical Nutrition Therapy.

Items not covered include Attention Deficit Hyperactivity Disorder, Asthma, Chronic fatigue, unspecified, and formal weight loss programs or maintenance for weight loss, are not covered. Please reference the Exclusions for other that may not be covered.

J. Private Duty Nursing

Services provided by Private-Duty Nurses to You or Your Covered Dependent in the home will be Covered up to the Plan Limitation per Calendar Year as indicated on Your Benefits Chart.

Private duty nursing Services in the Inpatient setting are excluded.

K. Reconstructive Surgery Following Mastectomy

We comply with the Women's Health and Cancer Rights Act, with respect to health Benefits offered through this Plan. The Women's Health and Cancer Rights Act provides that Group Health Plans will provide Coverage for Reconstructive Surgery and Prosthesis following mastectomies. This includes reconstruction of the breast on which the Mastectomy was performed; Reconstructive Surgery of the other breast to present a symmetrical appearance; Prosthesis; and treatment of physical complications of all stages of the Mastectomy procedure, including lymphedemas.

We cover Breast prosthesis whether internal or external, following a mastectomy, and 4 surgical bras per Calendar Year, as required by the Women's Health and Cancer Rights Act.

L. Other Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or development abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy.

Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a covered service under the plan; coverage for reconstructive services does not apply to orthognathic surgery.

M. Routine Patient Care during a Cancer Clinical Trial

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:

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

- 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;
- Tests responses to a Health Care service, item, or drug for the treatment of cancer;
- 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;
- Studies new uses of a Health Care service, item, or drug for the treatment of cancer.

- The trial is approved by one of the following entities:
- The National Institutes of Health or one of its cooperative groups or center under the United States Department of Health and Human Services;
- The United States Food and Drug Administration;
- The United States Department of Defense or Department of Veteran's Affairs.

N. Routine Patient Care during an Approved Clinical Trial

We will cover Routine Patient Care administered to an insured participating in a federally funded or an approved clinical trial that is defined as a Phase I, Phase II, Phase III, Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening diseases or conditions. An Eligible clinical trial will meet the following criteria:

1. A determination has been made that Your participation in the approved clinical trial is appropriate to treat Your disease or condition.
2. A federally funded or approved trial.
3. A clinical trial conducted under an FDA investigational new drug application.
4. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Contact the AultCare Service Center to discuss Your clinical trial benefit and the availability of Network and Non-Network Providers participating in clinical trials. You may be responsible for amounts above RBP for Non-Network Providers.

We will not do the following:

1. Deny participation in a federally funded or approved clinical trial.
2. Deny or limit, or impose additional conditions on the Coverage of Routine Patient Care/costs for items and Services furnished to You in connection with an approved clinical trial.
3. Discriminate against You on the basis that You are participating in a clinical trial.

O. Skilled Nursing Facility

1. We Cover Skilled Nursing Facility Services for 90 days per year when:

    a. Care is provided by a Skilled Nursing Facility.

    b. Care is not Custodial.

2. If You use a Non-Network provider, You may have a higher Cost Share and be subject to Balance Billing.

P. Transplants

We Cover Medically Necessary transplants, including Bone Marrow/Stem Cell, Heart, Heart/Lung, Cornea, Large and Small Bowel, Lung, Liver, Kidney, and Pancreas.

The initial evaluation and any necessary additional testing to determine Your Eligibility as a candidate for transplant by Your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure Benefit regardless of the date of service. Approval for an evaluation is not approval for the Transplant itself.

The above Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member Cost Share.

We do not cover transplants that are Experimental or Investigational or those that are in Non-Approved Clinical Trials, with the exception of Services relating to Routine Patient Care.

Covered Transplant Procedure include any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

- Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure are covered under this Plan. The Unrelated donor search Benefit is limited to $30,000 per Transplant.

- Live donor health Services are also covered under this Plan, but limited to benefits not available to the donor from any other source.

- Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Contact the UM Department for specific Network transplant Provider information for Services received at, or coordinated by a Transplant Specialty Network. A Transplant Specialty Network is a specialized Network of transplant centers and providers approved to perform related services at the panel level of benefits. This Network is separate from Your primary medical Network of facilities and providers. Not all transplant facilities

are within the Transplant Specialty Network. You will receive the highest level of benefit under Your plan when You use a facility within the Transplant Specialty Network.

1. **Pre-Approval and Pre-Certification**

   We require a Referral, please have Your Physician submit a request to Our UM Department to discuss Benefit Coverage when it is determined a transplant is Medically Necessary. Contact the AultCare Service Center telephone number on the back of Your Identification Card with any questions. We will assist You in maximizing Your Benefits by providing Coverage information, including details regarding what is covered and whether any clinical Coverage guidelines, medical policies, Network Transplant Provider requirements, or Exclusions are applicable. Even if We issue Pre-Approval for the Covered Transplant Procedure, You or Your Provider must call Us for Pre-Certification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

   There are instances where Your Provider requests approval for Human Leukocyte Testing (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. HLA is used to identify certain individual variations in a patient's immune system. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

2. **Transportation and Lodging (Applies once Your Transplant is approved)**

   The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when You obtain Pre-Approval for Your transplant and are required to travel more than 75 miles using the most direct route from Your residence to reach the facility where Your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion, all charges will need to be reasonable, necessary, and itemized.

   If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when Claims are filed. Contact Us for detailed information. The Transplant Transportation and Lodging benefit is limited to $10,000 per Transplant.

3. **Organ Transplant related exclusions include:**

   - Child care
   - Mileage within the medical transplant Facility city
   - Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us
   - Frequent Flyer miles
   - Coupons, Vouchers, or Travel tickets
   - Prepayments or deposits
   - Services for a condition that is not directly related, or a direct result, of the transplant

- Telephone calls
- Laundry
- Postage
- Entertainment
- Interim visits to a medical care Facility while waiting for the actual transplant procedure, Travel expenses for donor companion/caregiver, return visits for the donor for a treatment of a condition found during the evaluation
- Travel expenses for donor companion/caregiver
- Return visits for the donor for treatment of a condition found during the evaluation

Q. Diabetic Education

We Cover diabetes Self-Management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Preventive Care Services” “Physician Home Visits and Office Services”. Screenings for gestational diabetes are covered under “Preventive Care.”

R. Medical Nutrition Therapy (MNT)

Medical Nutrition Therapy is covered for disease states in which dietary adjustment is part of treating the disease and therapeutic outcomes are expected. It must be prescribed by a licensed physician and provided by a registered dietitian nutritionist, or other licensed professional trained in medical nutrition therapy.

The plan covers nutritional counseling for disease states including but not limited to diabetes, renal disease, heart disease, lung disease and digestive disorders.

Nutrition counseling for diabetes includes diet education for prediabetes, new onset diabetes, and uncontrolled diabetes.

S. Vision Care

We cover the cost of an initial eye examination following cataract surgery or Accidental Injury, including the initial cost of lenses and frames.

Medically necessary contact lenses are dispensed in lieu of other eyewear as explained in the Prosthetics section. Participating providers will obtain the necessary Prior Authorization for these services.

Pediatric Vision

Pediatric vision is also covered under this Plan through the end of the month in which a member turns 19 years of age. Pediatric benefits include:

1. A Routine Eye Exam, including eye refraction is covered in full every Calendar Year. This includes dilation, if professionally indicated.

2. One pair of standard eyeglass lenses and frames are covered every Calendar Year subject to Network and Non-Network Cost Share. Covered lenses include:

   - Ultraviolet Protective Coating
   - Polycarbonate Lenses (if not child, monocular or prescription
   - Blended Segment Lenses
   - Intermediate Vision Lenses
   - Standard Progressives
   - Premium Progressives (Varilux®, etc.)
   - Photochromic Glass Lenses
   - Plastic Photosensitive Lenses (Transitions®)
   - Polarized Lenses
   - Standard Anti-Reflective (AR) Coating
   - Premium AR Coating
   - Ultra AR Coating
   - Hi-Index Lenses

   Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, oversided and glass-grey#3, prescription sunglass lenses.

   Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions greater than +/- 6.00 diopters.

   All lenses include scratch resistant coating with no additional copayment.

3. The contact lens benefit is in lieu of eyeglasses. Contact fitting, evaluation and follow-up care for regular contact lenses is included.

   - V2100-2199 Single Vision
   - V2200-2299 Conventional (Lined) Bifocal
   - V2300-2399 Conventional (Lined) Trifocal
   - V2121. V2221, V2321 Lenticular

4. Low vision benefits; Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and

provide training and instruction to maximize the remaining usable vision for our members with low vision.

After Pre-Approval, covered low vision services (both Network and Non-Network) will include one comprehensive low vision evaluation every 5 years, and low vision aids such as high-power spectacles, magnifiers and telescopes; and follow-up care (four visits in any five-year period). Participating providers will obtain the necessary Pre-Approval for these services.

IMPORTANT: If You opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge You his or her normal fee for such services or materials. Prior to providing You with vision care services or vision care materials that are not covered benefits, the vision care provider will provide You with an estimated cost for each service or material upon Your request.

If You choose to purchase services or materials that are not covered under the Plan, You may have a higher Out-of-Pocket cost.

Section 21 – Managed Prescription Drug Program

Some Plans may offer 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.

A. Formulary and Non-Formulary

AultCare's formulary is designed to provide value. Only specific drugs in each therapeutic class are covered. The formulary design provides adequate options in each therapeutic category and includes most generics and selected brands. Medications on this formulary list may not be covered by the plan You select. Please consult the list of exclusions contained in Your plan booklet. Medications not listed on our formulary are not covered under the plan. Please note, if a non-formulary Brand Name drug is approved, it will be covered at the Non-Preferred benefit.

You, Your authorized representative, Your Physician, or other Prescriber that is treating You has the right to request Coverage of clinically appropriate **Non-Formulary** medication. This is called a request for an exception. Contact our AultCare Service Center at 330-363-6360 or 800-344-8858 if You would like to request an exception of a Non-Formulary medication.

B. Tier Definitions

The medication tier may change due to new drugs and generic availability. For a current list, please visit the AultCare website at www.aultcare.com or call the AultCare Service Center at 330-363-3630 or 1-800-344-8858. Not all plans have a tiering structure. Your Benefits Chart will indicate whether or not Your plan has tiers.

1st Tier is defined as Preventive Maintenance List drugs
2nd Tier is defined as Preferred Generic drugs

3rd Tier is defined as Preferred Brand and Non-Preferred Generic drugs
4th Tier is defined as Non- Preferred Brand and Non- Preferred Generic drugs
5th Tier is defined as Preferred Generic Specialty Medications that are treatments for chronic illnesses. Prior Authorization is required and will be limited to a 30-day supply through a specialty Network pharmacy.
6th Tier is defined as Preferred Brand Specialty Medications that are treatments for chronic illnesses. Prior Authorization is required and will be limited to a 30-day supply through a specialty Network pharmacy.

There are no tier exceptions. For example, a higher tier (Non-Preferred) medication may not be requested at a lower tier (Preferred) Copay.

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

BRAND NAME DRUG means a medication sold by a pharmaceutical company under a trademark-protected name. Brand name medications can only be produced and sold by the company that holds the patent for the drug. Brand name drugs may be available by prescription or over the counter.

PREVENTIVE MAINTENANCE DRUG means a medication that can help people avoid many illnesses and conditions. Using these medications as directed by health care provider can help support the goal of ongoing good health. For a complete list of the AultCare Preventive Maintenance List, please visit our website at www.aultcare.com or if You would like a paper copy, You may call the AultCare Service Center at 330-363-6360 or 1-800-344-8858.

SPECIALTY/LIMITED DISTRIBUTION means a medication or treatment for chronic illnesses that require special handling techniques, careful administration, and a unique ordering process. Some Specialty medications are considered Limited Distribution and are only available at certain pharmacies. (SP)

PREFERRED STATUS means that the product is a more cost effective choice within a therapeutic category.

NON PREFERRED STATUS means that the product is not a more cost effective choice within a therapeutic category.

C. Covered Services

- Drugs approved by the U.S. Food and Drug Administration (FDA) and that are required by federal or state laws to be dispensed to the public only on prescription of a licensed physician or other licensed provider.
- Compound medication - The primary ingredient must be an FDA approved medications and not deemed experimental and or investigational.
- Insulin (prescription only), Insulin syringes/needles (prescription only)
- Injectable medications
- Over-the counter medications required under Health Care Reform/Preventive Care Guidelines
- Tobacco cessation medications, aids, and devices required under Health Care Reform/Preventive Care Guidelines

- Contraceptive medications, injectables, and devices
- Migraine medications
- Growth Hormones – Prior Authorization is required
- Prenatal vitamins only. All others are a plan exclusion
- Immunosuppressives
- Vaccines – Flu, Pneumonia, & Shingles are covered at 100% at the pharmacy. The Shingles vaccine is available for enrollees age 50 or older.
- FreeStyle Libre Sensor and Reader

D. Services Not Covered

- Lost, Stolen, or Damaged medications
- Experimental, investigation or unproven drugs
- Blood or Plasma
- Therapeutic devices or appliances, including support garments and other non-medical substances, unless otherwise specified.
- Charges for injections or administration of a drug
- A prescription that may be received without charge under Worker's Compensation Laws or other local, state, or federal programs. This would include medications taken for occupational injury/disease.
- Prescriptions that are not self-administered or medication that is to be taken or administered to an individual in a licensed hospital, nursing home, physician's office/clinic or similar institution where such medications are normally provided by the facility on an in-patient basis.
- Prescription refills in excess of the number specified or dispensed more than one year from the date of the original order.
- Needles and syringes, other than for insulin
- Durable medical equipment including glucose monitors
- Over-the-counter medications, except for Insulin and Loratadine. All medications required under Health Care Reform/Preventive Care Guidelines are covered.
- Medical supplies
- Diabetic supplies and devices: including control solution, sensors, glucose test strips, urine test strips, acetone test strips, lancet devices, and lancets
- Impotence medications
- Fertility Medications
- Vitamins, except Prenatal
- Drugs for cosmetic purposes only
- Weight loss medications
- Immunizing agents and Biological Sera
- Lucentis (covered under medical and does not require Prior Authorization)
- Medicinal Foods
- Medical Devices
- Drugs obtained from pharmacies not located in the United States
- Charges incurred outside the United States if the Covered Person traveled to such location for the sole purpose of obtaining a drug

E. Prior Authorization

Prior Authorization is an evaluation of Your medications by Your Provider and AultCare medical professionals to determine the appropriateness of the medications requested. It means You or Your Network Provider must notify AultCare Pharmacy before You may receive certain medications.

Certain medications may be covered under medical, require Prior Authorization, have step therapy, and/or may have plan limitations. Prior Authorization may limit the number of day supply for certain medications. Medications requiring Prior Authorization are reviewed to determine medical necessity and/or the appropriateness of the medication or services requested based on AultCare clinical criteria/guidelines. Medications not on our formulary must meet AultCare clinical criteria/guidelines through an exception process in order to be considered for coverage under plan benefits. Please visit the AultCare website at www.aultcare.com or call the AultCare Service Center at 330-363-6360 or 1-800-344-8858 for any questions regarding these processes.

How to Request Prior Authorization:

- Your physician will need to complete the enrollment form specific for the medication being requested.

- This will be reviewed by the AultCare Pharmacy clinical team.

You have a Right to:

- Receive basic information about which drugs will require Prior Authorization.

- Receive Prior Authorization for medications used to treat chronic diseases under certain circumstances up to a 12-month period or until the last day of eligibility under Your policy or plan, whichever is lesser.

- For a Pre-Service, non-urgent Prior Authorization request, We will make a Coverage determination and notify You, Your authorized representative, Your Physician, or other Prescriber no later than 10 days following receipt of the request. For a Pre-Service urgent Prior Authorization request, We will make a Coverage determination and notify You, Your authorized representative, Your Physician, or other Prescriber no later than 48 hours following receipt of the request.

Prior Authorization is required for narcotic analgesic or opioid medications that are used for treating chronic pain, except in the case of cancer, terminal illness, or hospice. These Prior Authorization requests will be handled within the expedited timeframe, which is 48 hours following receipt of the request. AultCare is compliant with all state and government regulations regarding opioid use through non-pharmacological options, access to substance abuse treatment options and Fraud Waste and Abuse oversight.

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

We will not limit/exclude coverage for drugs approved by the U.S. Food and Drug Administration for the treatment of indications for which the drug has been prescribed. The medication must have support for the

requested off-label use in one or more of the standard medical reference compendia adopted by the U.S. Department of Health and Human Services or the off-label use must be supported in at least two articles from major peer reviewed medical journals and no article from a major peer-reviewed journal has concluded that the drug is unsafe or ineffective for the condition for which it is prescribed. The clinical management tools described above help to guide appropriate use of medications when prescribing for off label use.

F. Formulary Exception Process

A Formulary Exception request is an evaluation of Your medication, not listed under the managed formulary, by Your Provider and AultCare medical professionals to determine the appropriateness of the medication requested. It means Your or Your Network Provider must notify AultCare Pharmacy before You may receive certain medications not listed on the plan's managed formulary.

Medications not on our formulary must meet AultCare clinical criteria/guidelines through an exception process in order to be considered for coverage under plan benefits. Please visit the AultCare website at www.aultcare.com or call the AultCare Service Center at 330-363-6360 or 1-800-344-8858 for any questions regarding these processes.

Standard Exception

We will make a Coverage determination on a standard exception request and notify You, Your authorized representative, Your Physician, or other Prescriber no later than 72 hours following receipt of the request.

If We approve Your exception request, We will provide Coverage of the non-formulary drug for the duration of the prescription, including refills. The medication will be covered as an essential health benefit, including counting it towards Your plans annual out of pocket maximum.

Expedited Exception

In order for an expedited exception request to be considered "expedited", You, Your authorized representative, Your Physician, or other Prescriber must state that an expedited review is necessary due to exigent circumstances.

Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

We will make a Coverage determination on an expedited exception request and notify You, Your authorized representative, Your Physician, or other Prescriber no later than 24 hours following receipt of the request.

If We approve Your exception request, We will provide Coverage of the non-formulary drug for the duration of the exigency prescription, including refills. The medication will be covered as an essential health benefit, including counting it towards Your plans annual out of pocket maximum.

External Exception

If We deny Your request for a standard exception or an expedited exception, You have the right to request an External Review by an Independent Review Organization.

The Independent Review Organization will make a determination on a standard external exception request, and We will notify You, Your authorized representative, Your Physician, or other Prescriber no later than 72 hours following receipt of the request. For an expedited external exception request, We will notify You, Your authorized representative, Your Physician, or other Prescriber no later than 24 hours following receipt of the request.

If We approve Your exception request, We will provide Coverage of the non-formulary drug for the duration of the prescription, including refills. If We approve Your exception request based on exigent circumstances, We will provide Coverage of the non-formulary drug for the duration of the exigency. The medication will be covered as an essential health benefit, including counting it towards Your plans annual out of pocket maximum.

G. Step Therapy Program

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

You, Your authorized representative, Your Physician, or other Prescriber that is treating You has the right to request Coverage of a prescription that is restricted under AultCare's Step Therapy program. If the exemption is approved, coverage will be provided at the appropriate benefit level.

We will make a Step Therapy request determination for an urgent exemption request within 48 hours and all other exemption requests will be made in 10 days.

We will grant exemption requests in certain circumstances.

- The Step 1 prescription drug is not recommended for You based on federal prescribing information;
- You have tried the Step 1 medication and its use was discontinued due to a lack of efficiency, diminished effect, or an adverse event;
- You are stable on Your current prescription drug.

You, Your authorized representative (You have the right to appoint a representative, including an attorney to act on Your behalf), Your Physician, or other Prescriber have a right to appeal denials. You are eligible for one level of appeal and an external review (if eligible). It is intended to provide You with a full and fair review of the denial. Please see Sections 32 and 33 for more detailed information regarding timeframes for review.

H. Preventive Health Services

In response to the Patient Protection and Affordable Care Act (PPACA), certain preventive medications are available and covered without cost- sharing. The availability or coverage of these medications without cost-sharing may be subject to criteria established by the terms of Your health plan. This list is subject to change as ACA guidelines are updated or modified.

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

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

For a complete list of these medications, please visit the AultCare website at www.aultcare.com or call the AultCare Service Center at 330-363-6360 or 1-800-344-8858.

In response to the Women's Preventive Services Act, certain birth control medications will be covered at a zero ($0) Copay. The Plan will cover at least one form of Birth Control from each FDA approve method at 100%. Some medications may require specific criteria to be met.

In the event a member requests coverage for a birth control product not on the standard coverage list, a Prior Authorization will be required, and the Plan will make the determination of coverage.

If approved, the medication or item will be covered at 100%. Medical Necessity may include considerations such as severity of side effects, difference in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or services.

I. Oral Cancer Medications

Please note that orally administered cancer medication Coverage shall be no less favorable than Coverage for intravenous and injected cancer medications in accordance with state law.

J. Specialty/Limited Distribution Medications

Specialty medications are treatments for chronic illnesses that require special handling techniques, careful administration, and a unique ordering process. Some Specialty medications are considered Limited Distribution and are only available at certain pharmacies. Prior Authorization is required for Specialty/Limited Distribution medications and will be limited to a 30-day supply. These medications must be obtained through a specialty Network pharmacy. For information regarding these pharmacies, please visit our website at www.aultcare.com or You may call the AultCare Service Center at 330-363-6360 or 1-800-344-8858.

K. Long-term Prescriptions

For long-term ongoing prescription drug needs, You can receive up to a 90-day supply through Your mail order prescription program. When participating in the mail order program, You pay the appropriate Copay per 90-day supply. The mail order pharmacy must fill Your prescription for the exact quantity of medications prescribed by Your doctor, up to the 90-day plan limit. This applies only to drug Tiers 1 through 3.

L. Pharmacy Networks

You can enjoy the convenience of local and national pharmacy service at discounted Network pricing. Please remember to present Your card at the pharmacy for Your prescriptions. If a prescription is purchased without using Your card, You must purchase the prescription and mail into AultCare for reimbursement. For a pharmacy listing, please visit the AultCare website or contact the AultCare Service Center.

If Your plan utilizes a Preferred Pharmacy Network, please refer to the Summary of Benefits and Coverage for the appropriate co-pay representation for preferred and non-preferred pharmacy Network.

M. General Managed Prescription Information

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

If You didn't use Your member ID card for a prescription allowed by Your plan, You can submit a claim for reimbursement. Your reimbursement claim will be considered based on Your plan allowable amount. AultCare will reimburse up to the maximum amount AultCare would pay if You used Your ID card.

AultCare will not pay any Covered Person any rebate that AultCare may receive related to utilization of pharmacy benefits.

Third party coupon or Copay discount or coupon card assistance provided by a drug manufacturer for specialty or other qualified medications will not apply toward the Plan's Deductible or Out-of-Pocket limit.

If coverage under Your medical plan terminates, Your prescription drug benefit will also terminate. If a covered person continues to use their prescription drug benefit, they will be held responsible for payment of any bills on or after the termination date.

N. Coordination of Benefits Information

Coordination of Benefits is the process in which two or more health insurers cover the same person(s) but limit the total benefit for a claim to an amount not exceeding the total cost of the claim.

If AultCare is your secondary benefit, primary claims submitted by the retail pharmacy or primary paper claims submitted by You will not be covered.

Coordination of Benefits applies to:

- Your mail order pharmacy claims
- Your member-submitted pharmacy claims
- Your retail pharmacy claims

Only prescription drug products covered under this Plan are eligible for payment. Payments are subject to this Plan's applicable Coinsurance, Copayments and Plan provisions and limitations.

For further information on Coordination of Benefits or for an explanation on the reimbursement of a claim, please call AultCare Service Center at 330-363-6360 or 1-800-344-8858 for any questions regarding this process.

Section 22 – Exclusions/Non-Covered Services

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items that may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1. Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

2. Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us.

3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

4. This plan is not a Workers' Compensation policy and is not issued in lieu thereof. The Certificate does not satisfy any requirements for coverage by Workers' Compensation insurance. This plan does not cover:

    - Charges for any condition, disease, defect, ailment, or injury arising out of and in the course of employment with any employer who is eligible to obtain coverage under any Workers' Compensation Act or similar law.
    - Injuries at work if Workers' Compensation is available, required, or applicable, regardless of whether a Workers' Compensation claim is filed.

    - Charges for You, Your Dependents or Spouse for a work related injury while self-employed if eligible to obtain coverage under any Workers' Compensation Act or similar law.

    If Workers' Compensation Benefits are not available to You, this exclusion does not apply.

5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

6. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

8. For court ordered testing or care, unless Medically Necessary.

9. For which You have no legal obligation to pay in the absence of this or like coverage.

10. For the following:

    - Surcharges for furnishing and/or receiving medical records and reports.

    - Charges for doing research with Providers not directly responsible for Your care.

    - Charges that are not documented in Provider records.

    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.

    - For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

11. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

12. Prescribed, ordered or referred by or received from a member of Your immediate family, including Your spouse, child, brother, sister, parent, in-law, or self.

13. For completion of claim forms or charges for medical records or reports unless otherwise required by law.

14. For missed or canceled appointments.

15. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

16. For which benefits are payable under Medicare Parts B, and/or D when Medicare is primary. If Medicare is not primary, this exclusion does not apply if a person is or could have been covered under another plan, except with respect to Part B of Medicare. For the purposes of the calculation of

benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.

17. Charges in excess of Our Maximum Allowable Amounts.

18. Incurred prior to Your Effective Date.

19. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.

20. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.

21. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

22. For the following:

    - Custodial Care, convalescent care or rest cures.

    - Domiciliary care provided in a residential institution, treatment center, supervised living or halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

    - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, halfway house, or outward bound programs, even if psychotherapy is included.

    - Wilderness camps.

23. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:

    - Cleaning and soaking the feet.

    - Applying skin creams in order to maintain skin tone.

    - Other services that are performed when there is not a localized illness, injury or symptom involving the foot.

24. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

25. For dental treatment, regardless of origin or cause, except as specified elsewhere in this Certificate. Dental treatment includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:

    - Extraction, restoration and replacement of teeth.

    - Medical or surgical treatments of dental conditions.

    - Services to improve dental clinical outcomes.

26. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

27. For Dental implants for adults. This exclusion does not apply to dependents under 19.

28. For Dental braces for adults. This exclusion does not apply to dependents under 19.

29. For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:

    - Transplant preparation.

    - Initiation of immunosuppressives.

    - Direct treatment of acute traumatic injury, cancer or cleft palate.

30. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

31. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

32. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

33. For marital counseling.

34. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

35. For vision orthoptic training.

36. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Certificate.

37. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

38. For services to reverse voluntarily induced sterility.

39. For treatment related to infertility.

40. For personal hygiene, environmental control, or convenience items including but not limited to:

    - Air conditioners, humidifiers, air purifiers; Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;

    - Charges for non-medical self-care except as otherwise stated;

    - Purchase or rental of supplies for common household use, such as water purifiers;

    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;

    - Infant helmets to treat positional plagiocephaly;

- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

41. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

42. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy, keratomileusis, or excimer laser refractive keratectomy.

43. For self-help training and other forms of non-medical self-care, except as otherwise provided in this Certificate.

44. For examinations relating to research screenings.

45. For stand-by charges of a Physician.

46. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, unless within the parameters of mandated preventive care benefits.

47. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.

48. For Manipulation Therapy services rendered in the home as part of Home Care Services.

49. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

50. For any services or supplies provided to a person not covered under the Certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

51. For surgical treatment of gynecomastia.

52. For treatment of hyperhidrosis (excessive sweating).

53. For any service for which You are responsible under the terms of this Certificate to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

54. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Us through Prior Authorization.

55. Complications directly related to a service or treatment that is a non-Covered Service under this Certificate because it was determined by Us to be Experimental/Investigational or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

56. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This Exclusion does not apply to over-the-counter products that We must cover under federal law with a Prescription.

57. For Drugs obtained from pharmacies not located in the United States.

58. Charges incurred outside the United States if the covered person traveled to such location for the sole purpose of obtaining a drug.

59. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

60. Treatment of telangiectatic dermal veins (spider veins) by any method.

61. Reconstructive services except as specifically stated in the Covered Services section of this Certificate, or as required by law.

62. Nutritional and/or dietary supplements, except as provided in this Certificate or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

63. For room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission for Your condition.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when

the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;

- has been determined by the FDA to be contraindicated for the specific use; or

- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation. Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

    - the scientific evidence is conclusory concerning the effect of the service on health outcomes;

    - the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

    - the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and

    - the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Us to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- documents of an IRB or other similar body performing substantially the same function; or

- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- medical records; or

- the opinions of consulting Providers and other experts in the field.

We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Section 23 – Using Your AultCare Card

A. Information On Your Card

On the front of Your AultCare Card, You will find:

1. Your name.
2. Your Group Number.
3. Your Member Identification Number.
4. Whether Your Coverage is Individual or Family.
5. The Effective Date of Coverage.
6. The amount of Your Copay.
7. Our website www.aultcare.com.

On the back of Your AultCare Card, You will find:

1. Our address, including where You can submit Claims.
2. The AultCare Service Center telephone numbers, 330- 363-6360 and 800-344-8858.

3. Our weekday hours of operation.

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

B. When You Need to Show Your AultCare Card and Why

You will need to show Your AultCare Card when You go to a Provider for Services. Your Doctor or Health Care Provider will verify that You are Covered by checking Your Group 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 Card. Always take Your most current AultCare Card with You.

Section 24 – Your Responsibility for Copayments, Deductibles, Coinsurance

A. Your Responsibility for Copayments

A Copayment (or Copay) is the set dollar amount You pay Out-of-Pocket for each Provider Office Visit.

B. Your Responsibility for Deductibles

A Deductible means a set annual dollar amount of medical expenses You must pay before the Master Group Policy pays.

C. Coinsurance

Coinsurance is the percentage of medical expense You share with the AultCare Insurance Company after You meet Your Annual Deductible.

Section 25 – Reference Based Pricing ("RBP")

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 amount We pay to a Network Provider for the same Service. You are responsible for paying the balance between the total charges and the amount We pay to Non-Network Providers. 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 AultCare Service Center for assistance.

REFERENCE BASED PRICING ALLOWANCE (RBP) means allowable fees for Covered Services. For Network Providers, RBP means the professional fees We have negotiated with them. For Non-Network Providers, RBP 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. We will not pay that portion of Non-Network Provider fees that exceeds RBP. 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 RBP amount We have determined for this procedure is $100, then We will pay up to the RBP amount ($100), minus Your Cost Share. You would be responsible for paying the amount that exceeds RBP, which is $25 plus any Cost Share.

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

Section 26 – Filing Your Claim

A. Claims for Hospital Services

When Services are provided at a Hospital, show Your AultCare 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, except that if You request an Application for Benefits and do not receive one from AultCare within fifteen days of Your request, You may submit written proof covering the occurrence, character and the extent of the loss for which the claim is made, and once that is filed We may follow up with You with for more information

C. Time Limits for Filing Claims

Generally, You must file a Claim within 24 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. Prompt Payment

Once We have received Your Claim, We will consider it for payment according to the written guidelines of the Plan, including Cost Share whether Services were Network Provider or Non-Network Provider, and RBP. We will process Your Claim within 30 days. If Your Claim is incomplete, We will extend the time for determination until We have received any requested information, generally within a timeframe not to exceed 45 days. If We do not receive additional information necessary to process Your Claim, Your Claim may be denied. You will be notified of any Claims decisions in writing.

E. 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, log onto our website at www.aultcare.com, or call Us at 330-363-6360 or 1-800-344-8858.

Section 27 – 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, 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 disclosing another's Protected Health Information without an Authorization except in limited circumstances.

Section 28 – Coordination of this Contract's Benefits with Other Benefits

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. 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 copay, which 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 two 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 two 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, Pre-Certification 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.

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 Coverage that are superimposed over base Plan Hospital and surgical Benefits, and insurance type Coverage that are written in connection with a Closed panel Plan to provide Non-Network Benefits.

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

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

1. Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent, for example as an Employee, 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:

        i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or

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

        iii. However, if one 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 (i) 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 (i) above shall determine the order of Benefits; or

c. If there is no court decree allocating responsibility for the Dependent Child's Health Care expenses or Health Care Coverage, the order of Benefits for the Child are as follows:

i. The Plan covering the Custodial parent;

ii. The Plan covering the Spouse of the Custodial parent;

iii. The Plan covering the non-Custodial parent; and then

iv. The Plan covering the Spouse of the non-Custodial parent.

d. For a Dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of Subparagraph (i) or (ii) 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. AultCare 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. AultCare Insurance Company need not tell, or get the consent of, any person to do this. Each person Claiming Benefits under This Plan must give AultCare 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, AultCare 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. AultCare 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 AultCare 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 800-344-8858 and 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 800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

Annual Requirement

Each year, You will be required to fill out an Other Coverage Information Form (OCIF). This form confirms there have been no changes in any member's status with regard to other Coverage. The OCIF needs to be filled out and returned promptly, as it may affect the processing of Your claims. If You have questions, please contact the AultCare Service Center at 330-363-6360 or for members outside Stark County, 1-800-344-8858 and a Customer Service Representative will help You. You can also supply the requested information online at www.aultcare.com.

Section 29 – Explanation of Benefits ("EOB")

AultCare processes an Explanation of Benefits (sometimes called an "EOB") that describes how We handled Your Claim. An EOB is not a bill. Your Provider may send You a bill, if needed. You may visit our website at www.aultcare.com to view Your EOB online, or, You may request a paper copy via mail.

The EOB describes the Group Number and the ID Number of the person who received Services, what Services were provided, who provided them, and the date they were provided, any adjustments to show Cost Share, additional fee adjustments or Exclusions that You may or may not be required to pay, the total amount AultCare paid on the Claim and the date it paid, and the amount, if any, You are responsible for paying.

Access Your Explanation of Benefits (EOBs) 24 Hours a Day

You can access, view or print Your EOBs from Your AultCare account any time You need them.

Go to AultCare's website at www.aultcare.com
"Click to Login" button on the left side of the screen or tiny login button above search box.

Registered users: enter username and passwords. New users: click "Register for a new account" and follow the "Steps for Registration". If You are a new user, within 2-3 weeks, You will begin receiving email notifications when an electronic EOB is posted.

Manage Your ready to view EOB email notification preferences:

- Once logged in, select "account" and then "alerts & emails"
- Click Claim EOB Ready Notification
- Click "ON" = sends email
- Click "OFF" = does not send email

Manage Your paperless statement delivery settings:

- Once logged in, select "account" and then "alerts & emails"
- Click Paperless Explanation of Benefits Statement
- Click "NO" to receive paper EOBs in the mail
- Click "YES" to receive EOBs electronically and no longer receive them in the mail

If You have questions or do not have internet access, call AultCare's Customer Service at 330-363-6360 or 800-344-8858. A service representative can answer Your questions and help You change Your EOB options over the phone.

Section 30 – Subrogation, Reimbursement and Other Insurance

A. Agreement

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

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, AultCare becomes Subrogated to all rights You have equal to the Benefit it 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. AultCare's right of Subrogation applies equally to all state, federal or common law Claims of survivors, wrongful death, loss of companionship (called "consortium") and other similar Claims. AultCare's right of Subrogation will not exceed the amount of the Benefit it paid or will pay to You**.**

AultCare's Subrogation right has "first priority" to any payment You receive. That means AultCare has a right to be repaid before anyone else, including You**,** any injured party, any attorney, any person with a Claim that arises out of, or results from, the illness or injury (called a "derivative Claim"), and any other person or entity with a Claim, right or lien on the payment. AultCare's Subrogation right will not be reduced by the amount of any attorney fees or costs You or any other party "incur" (including, but 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.

If You make a civil claim for a tort action seeking damages for injury, death, or loss to person, whether or not a lawsuit is pending, or a civil claim regarding uninsured or underinsured motorist coverage (but not a claim for breach of contract or agreement between persons), but You do not recover the full value of damages for Your claim because of: (1) comparative negligence; (2) diminishment due to joint and several liability; or (3) Your inability to collect the full value of the claim for injury, death, or loss to person due to limited liability insurance or any other cause, then notwithstanding any contractual or statutory

provision to the contrary, the rights of a subrogee (including AultCare, an insurance company doing business in Ohio, a self-funded plan providing health benefits, or any other person or entity that asserts a contractual, statutory, or common law subrogation claim against a third party or injured party in a tort action) will be diminished by the same proportion that Your interest in recovering damages is diminished. If You or another person disputes the distribution of damages recovered in a tort action, then either You or the other person may file a declaratory judgment action in common pleas court to resolve that dispute.

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

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 AultCare paid is not Yours to keep. That amount belongs to AultCare. You must pay back AultCare the amount equal to the Benefit AultCare had paid You within 14 calendar days from the date You received that payment.

Because some or all of the payment You are holding belongs to AultCare, any payment You, any injured party, any attorney or any other person or entity receives is subject to what is called a "constructive trust," or "equitable lien" that AultCare has on that payment, so it may be reimbursed. AultCare's right to be reimbursed continues, even if You use the payment to buy real estate, personal property, or other property. If AultCare is not timely reimbursed from any payment, it may reduce future payments for a Benefit to You until it is paid back in full.

AultCare's reimbursement right is first in priority to any payment received. It takes priority over You, any injured party, any attorney, any person with a derivative Claim, and any other person or entity with a Claim, right or lien on the payment. AultCare's reimbursement right will not be reduced for any attorney fees or costs You or any other person "incur" (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 AultCare "incurs" (see definition in Section B) to enforce its reimbursement right.

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

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 Policy may be secondary to the other collectable insurance Coverage. AultCare may require You to make a Claim for that Benefit with the other collectable insurance.

E. Your Cooperation

You, any injured party, any attorney and any other person or entity must cooperate with AultCare in the Subrogation, Reimbursement and Other Insurance process. You, any injured party, any attorney and any other person or entity must do whatever is necessary to let AultCare recover 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.

You must give AultCare any information it asks You to provide a soon as reasonably possible. You must promptly notify AultCare 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 AultCare in the investigation, settlement and protection of AultCare's rights.

You, any injured party, any attorney or any other person or entity must send AultCare copies of any police report, notices or other papers received in connection with the Accident or incident resulting in any illness or injury. You, any injured party, any attorney or any other person or entity must not settle or compromise any Claims, unless You notify AultCare in writing at least 30 calendar days before the settlement or compromise, and AultCare agrees to the settlement or compromise in writing.

You must complete, sign and return an Accident questionnaire and/or Subrogation agreement before 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

AultCare, in a manner consistent with Ohio law, will interpret and enforce the terms and conditions of the Subrogation, Reimbursement and Other Insurance provisions and will make determinations as to the amount that may be owed

SECTION 31 – Determination Time Frames

A. When You require urgent treatment, as determined by Your Provider, because You would be subject to adverse health consequences without the requested treatment or Your psychological state jeopardizes the life, health or safety of Yourself or others, a decision will be made once the request has been received from the Provider but no later than 48 hours after receipt of the request, unless You or Your Provider have provided insufficient information. If insufficient information has been provided to make the decision, We will notify You or Your Provider within 24 hours requesting the necessary information and will allow You or Your Provider 48 hours to respond.

B. We will make Prospective Review Determinations (Pre-Service) within 10 Calendar Days after receiving a proposed admission, procedure or Health Care Service that needs a Review Determination.

1. We will notify the Provider by secure electronic transmission, phone, letter, or fax regarding the Pre-Approval and will also let You know in writing.

2. If there is an Adverse Determination, We will notify the Provider by secure electronic transmission, phone, letter, or fax after making the Adverse Determination and will also let You know in writing.

C. We will make Concurrent Review Determinations after obtaining all Necessary Information.

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

2. We will notify the Provider by phone after making an Adverse Determination, and We will let You know in writing of that Adverse Determination. If You are receiving Services outside of the AultCare Network, You will be financially responsible for charges that exceed RBP.

3. We will notify the Provider within 24 hours after making a determination for urgent concurrent reviews.

4. We will provide notice for non-urgent concurrent reviews sufficiently in advance of the reduction/termination of benefits to allow the insured to appeal and obtain a determination of the review of the adverse benefit determination before reduction/termination.

D. We will make Retrospective Reviews (Post-Service) within 30 calendar days after receiving all Necessary Information.

E. 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.

F. You may have rights for other Claims review procedures under state law. Call Us if You have questions.

G. We will not retroactively deny a Pre-Approval for a health care service, drug, or device that was previously approved.

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. 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 800-344-8858 to speak with Your Service Representative. You may email Us at www.aultcare.com.

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 30 calendar days from the date You received Our notice to file this Complaint.

AultCare Grievance/Appeal Coordinator
P.O. Box 6029
Canton, Ohio 44706

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.

Complaints may be resolved quickly and easily by contacting AultCare. If AultCare's Internal Review process has been exhausted and You still wish to file a Complaint with the Ohio Department of Insurance, You may do so at that time. If You choose to file a Complaint with the Department of Insurance, send Your written Complaint to:

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

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

C. Types of Appeals

There are a number of Appeals that are available to You if We cannot resolve disagreements. You can Appeal any Adverse Determination by Us as to:

1. A Service that is not Covered.
2. A Service that is not Medically Necessary, Appropriate or Effective.
3. A Service that is Experimental or Investigational.
4. Rescission of Coverage.
5. A determination You are not eligible for Coverage.

You may also request an Expedited Review if Your medical condition needs prompt attention.

In the event of a Rescission, We will give You 30 days advanced notice before Coverage is Rescinded.

D. Denial or Rescission 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 of an Adverse Determination. You may ask for an Internal Review of an Adverse Determination because:

1. Service is not Covered or is Excluded or Limited under the terms of the Plan.

2. Service is does not meet requirements for Medical Necessity, appropriateness, Health Care setting or, level of care.

3. Service is Experimental or Investigational.

4. Rescission of Your Coverage.

5. You are not eligible for Coverage.

You, or someone acting for You, or Your 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. You will be permitted to view Your file and present evidence and testimony. You will be provided free of charge any new or additional evidence and the rationale for any adverse Benefit determination. Enrollees will be permitted to receive continued Coverage pending outcome of Appeals process.

The Company must notify You of a Benefit determination for any Claim involving Urgent Care as soon as possible but not later than 24 hours. Concurrent internal and External Reviews shall be allowed for Claims involving urgent care or an ongoing course of treatment.

You have the right to an External Review if the Company fails to adhere to internal Claims and Appeals processes. However, de minimis violations that do not cause or are not likely to cause prejudice or harm to the Claimant, which were for good cause or beyond the control of the Plan or Us, and which occurred in the context of an ongoing, good faith exchange of information will not give rise to a right to an External Review prior to the completion of an Internal Review.

Requests for Internal Review can be sent to the Grievance/Appeal Coordinator at:

AultCare Grievance/Appeal Coordinator
P.O. Box 6029
Canton, Ohio 44706

E. Internal Review When the Adverse Determination Is Because Services Are Not Covered

If We deny, reduce or terminate the Service because it is not Covered or is excluded or limited by the Plan, 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, Third Floor - Suite 300, 50 W. Town Street, Columbus, Ohio 43215, or call the Department of Insurance at 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 or is excluded or limited, We do not have to pay for the Service. If the Department determines that the Service is a Covered Benefit and is not excluded or limited, We must pay for the Service (You will need to pay Your Cost Share) or initiate an External Review by an Independent Review Organization. The Plan 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. Internal Review When Denial Is Because Services Are Not Medically Necessary, Appropriate or Effective

If We deny, reduce or terminate payment for the Service based on medical judgment or medical information because the Service does not meet requirements for Medical Necessity, appropriateness, Health Care setting or, level of care, You may ask for an Internal Review. A Clinical Peer will conduct this review. A Doctor will be the Clinical Peer when the Service being evaluated is the kind of treatment provided by Doctors.

The Clinical Peer will review Your medical records to determine if the Service meets requirements for Medical Necessity, appropriateness, Health Care setting and level of care. If the Clinical Peer determines the Service is Medically Necessary, appropriate and effective, We will Cover the Service. You still would be responsible for paying Your Cost Share. If the Clinical Peer determines that the Service is not Medically Necessary, appropriate or effective, then We may continue to deny the Service. If payment for the Service is denied, reduced or limited, 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 within 72 hours.

G. Internal Review When Denial Is Because Services Are Experimental or Investigative

You may ask for an Internal Review if We deny, reduce or limit payment for 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 Your Cost Share. If the Clinical Peer determines that the Service is Experimental or Investigative, We will deny Coverage. If You meet certain statutory requirements You may ask for an External Review, which may be Expedited.

H. Internal Review for Retrospective Review of Claim Requiring Pre-Approval

You may ask for an Internal Review of Your Claim if We denied a Service that required Pre-Approval but was not requested if certain criteria is met.

The Internal Review request must be in writing. We will do a Retrospective Review if the Service is directly related to another Service for which Pre-Approval was obtained and performed. The Service must not have been known to be needed at the time of the original review determination and the need for the new Service must have been revealed during performance of the original Service. Once all written information has been submitted, We will review Your Claim for Coverage and Medical Necessity.

I. Internal Review for Adverse Pre-Service Review Determinations

You or Your provider may ask for an Internal Review of an Adverse Pre-Service Determination. This review will be between Your Provider and a Clinical Peer.

For urgent care matters, in which You would be subject to adverse health consequences without the requested treatment or Your psychological state jeopardizes the safety of Yourself or others, We will make a determination regarding the appeal within 48 hours of receiving the request.

For all other matters, We will make a determination regarding the appeal within 10 calendar days of receiving the request.

If payment for the Service is denied, reduced or limited, You may ask for an External Review by an Independent Review Organization.

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 must let Us reconsider any Adverse Determination through the Internal Review process except in limited circumstances described in the Section on Expedited Reviews below. You may be able to skip the Internal Review process and go directly to an External Review by an Independent Review Organization. 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.

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

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

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

B. External Review Because Services are Not Covered or Coverage Is Rescinded

If We make an Adverse Determination because the Service is not Covered by this Plan, the Service is Excluded, You are not eligible for Coverage or Your Coverage was rescinded, You may request an External Review to be conducted by the Ohio Department of Insurance. You must request this review within 180 calendar days of receiving notice of the Adverse Determination as part of the Internal Review. Your request must be in writing to Us except if You request an Expedited Review, which is explained below.

C. External Review When Denial Is Because Services Are Not Medically Necessary, Appropriate or Effective

If We make an Adverse Determination based on medical judgment or medical information because the Service does not meet requirements for Medical Necessity, appropriateness, Health Care setting or level of care, You may request an External Review from an Independent Review Organization. The Independent Review Organization is not connected with AultCare.

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

The Independent Review Organization will review Your medical records to determine if the Service under review meets requirements for Medical Necessity, appropriateness, Health Care setting or level of care. If the Independent Review Organization finds that the Service does meet Plan requirements for Medical Necessity, appropriateness, Health Care setting or level of care, We will Cover that Service according to the terms of the Plan. If the Independent Review Organization finds that the Service does not meet Plan requirements for Medical Necessity, appropriateness, Health Care setting or level of care, We will not pay for it.

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

You may ask for an External Review when We make an Adverse Determination because Services were determined to be Experimental or Investigative, except if the Services are explicitly Excluded under the Plan. To qualify for this External Review, You must meet all of the following criteria:

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

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

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

    b. Standard therapies are not medically appropriate for You.

    c. There is no available standard therapy Covered by the Plan that will Benefit You more than the therapy You or Your Doctor requested.

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

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

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

E. Requesting an External Review by an Independent Review Organization

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

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

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

2. The rationale for the decision.

3. References to evidence or documentation that was considered.

If the Independent Review Organization finds that the Service is Medically Necessary, We will Cover the Service. You must pay the applicable Cost Share. 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

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

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

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

3. A Denial of Coverage concerns an admission, availability of care, continued stay, or Health Care service for which You received Emergency Services, but You have not yet been Discharged from a facility.

If a request for an Expedited Review is complete and eligible, We will transmit all necessary documents and information to the assigned Independent Review Organization, which will give You a decision within 72 hours of being assigned the Expedited Review.

B. Right to Request an Expedited Review Before An Internal Review is Completed

In certain circumstances, You may request an Expedited Review without having to first complete an Internal Review. An External Review may be requested before an Internal Review is completed in the following circumstances:

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

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

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

C. Determination by the Independent Review Organization

If the Independent Review Organization decides that the Service is Medically Necessary, appropriate and effective, We will Cover the Service. You must pay the applicable Cost Share. If the Independent Review Organization decides that the Service is not Medically Necessary, appropriate or effective, We will not Cover it.

Section 35 – Other Rights You May Have

You may have additional review and Appeal rights under Ohio or Federal law, as amended from time to time. We want You to know Your rights. Please check the Statement of ERISA Rights, which is attached to this document or call Your AultCare Service Representative if You have questions about Your rights.

Section 36 – Definitions

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.

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

ACCIDENT means an unforeseen injury caused by sudden, unexpected and sometimes violent means.

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 Master Group Policy.

ACTIVELY AT WORK means that to be Eligible, the Employee must be a Full-Time, permanent Employee, as required by the Employer, who is regularly working the required number of hours, is not on leave or laid off, and who receives a W-2 for the wages or salaries earned.

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. Adopted Child includes a Child placed for adoption where You assume and retain total or partial support of the Child in anticipation of the adoption of the Child.

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. An Adverse Determination may include a determination You are not eligible for Coverage or a Rescission of Your Coverage.

ALLOWABLE EXPENSE means the expense for Services that are Covered up to the Maximum Allowable Charge.

AMBULANCE TRANSPORTATION means a professional, licensed Ambulance company. It excludes private transportation.

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, the treatment is considered Experimental or Investigational, treatment is inappropriate or ineffective including issues related to Health Care setting and level of care, Your Coverage was rescinded, or You are not eligible for Coverage.

APPROVED REFERRAL means a Referral, made by Your Network Provider in advance, which permits You to receive Services from a Non-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 AultCare Insurance Company.

AULTCARE CARD means the identification card that You are issued, which contains Your name, Your Group Number, Your ID number, the Effective Date of Coverage, and important telephone numbers You can call. Always show Your AultCare Card when You go to a Provider for Services.

AULTCARE INSURANCE COMPANY is an insurance company affiliated with and a part of the AultCare family of Health Care Plans.

AULTCARE NETWORK means those Network Providers, listed in the AultCare Provider Directory, who provide medical and health care services to Enrollees under the Master Group Policy.

AULTCARE SERVICE CENTER means the office staffed by AultCare Representatives who are available to discuss with You questions about Coverage, rights and responsibilities and to assist You.

BEHAVIORAL HEALTH PROVIDER means an organization or individual professional who is properly licensed or certified to provide diagnostic, therapeutic or psychological services for mental disorders and substance abuse under the appropriate laws of the jurisdiction.

BENEFIT means Covered Charges for Covered Services You are entitled to receive under the Master Group Policy.

BENEFIT LEVEL (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 Provider or a Non-Network Provider.

BENEFIT YEAR means that period for which Benefit payments for Covered Services under the Plan are available.

BENEFITS CHART means an accompanying document, which includes limits and specific details about Your Benefits Plan and Cost Share amounts You must pay.

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.

BUSINESS DAY means normal hours of business, Monday through Friday, excluding holidays.

CALENDAR YEAR means January 1 through December 31.

CASE MANAGER means a person who is assigned to help monitor and assist You when You are Hospitalized or receiving other complex care.

CENTERS OF EXCELLENCE PROVIDER means an AultCare designated Non-Network Provider that meets quality and financial criteria that may be treated as Network. Pre-Approval by AultCare Utilization Management is required for Services to be paid at the Network level of Benefit in which RBP may not apply.

CERTIFICATE means this document, which generally explains the rules involving Eligibility, Coverage, Benefits and payment obligations as provided under the Master Group Policy between the Employer and AultCare Insurance Company.

CERTIFICATION (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.

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. A natural born Child of Yours; or

B. A legally Adopted Child of Yours or Child placed for adoption; or

C. A Stepchild; or

D. A Child for whom You are required to provide health insurance Coverage by court or administrative order.

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

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.

CMS (CENTER FOR MEDICARE AND MEDICAID SERVICES) is a U.S. Federal Agency within the Department of Health and Human Services that administers the Medicare and Medicaid programs.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, which requires that the Continuation of Group insurance Coverage be offered to Covered Persons who lose their health insurance due to a qualifying act, as defined by the Act.

COINSURANCE means a percentage of medical expenses that You share with AultCare Insurance Company after You meet Your Annual Deductible.

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.

CONCURRENT REVIEW means utilization review conducted during the patient's Hospital stay or course of treatment.

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.

CONTINUATION means Your ability to continue Coverage for a period of time under certain circumstances, even though You no longer are Covered under the Master Group Policy, so long as You meet the requirements and a Premium is paid.

CONTRACT YEAR means a period of 12 consecutive months as specified by the Master Group Policy.

CONTRIBUTION OR CONTRIBUTION RATE means the amount of Premium You are responsible for paying if Your Employer has a Contributory Plan.

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.

COPAYMENT (COPAY) 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.

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

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

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.

COVERAGE means You and Your Dependents are eligible to have AultCare pay Benefits for certain Services according to the Plan and subject to Cost Share, Exclusions and Maximums.

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 the participating Employer's Coverage.

COVERED PERSON means a person Eligible under the Plan to receive Coverage and Benefits.

COVERED SERVICES (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.

CUSTODY means that You have the responsibility for the supervision or control of a minor or person who lacks capacity.

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 (ANNUAL DEDUCTIBLE) means a specified dollar amount of covered Services, which the Covered Person must pay before AultCare pays Benefits. Deductibles begin on January 1 of each year.

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.

DEPENDENT means:

A. Your Spouse in a legal marriage; or

B. Your Child under the age of 26 years; or

C. A Child for whom You are required to provide health insurance Coverage by court or administrative order.

DIAGNOSTIC SERVICES mean laboratory, radiological or other Services intended to diagnose Your medical condition.

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.

DISCHARGE means the release from Hospital Confinement.

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.

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 or 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 are 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.

EDUCATION AND TRAINING means Techniques, procedures necessary for a member or family member to learn procedures or techniques to care for themselves as it relates to a disease state or condition for which a member is being treated.

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.

ELIGIBLE DEPENDENT means Your Spouse or natural or Dependent Children who meet certain requirements in order to participate as a Covered Person listed in the Certificate and receive Benefits.

ELIGIBLE EMPLOYEE means a Full-Time Employee who meets certain requirements in order to participate as a Covered Person and receive Benefits.

ELIGIBLE EXPENSES mean those expenses for Covered Services that may be paid under the Master Group Policy after You meet Your Cost Share requirements and subject to Maximum Allowable Charges. See also Allowable Expense.

ELIGIBLE PERSON means a Full-Time Employee or Dependent who meets certain requirements in order to participate as a Covered Person and receive Benefits.

ELIGIBILITY means established requirements that a person must meet in order to participate as a Covered Person under the Master Group Policy and receive Benefits.

EMERGENCY MEDICAL CONDITION (MEDICAL EMERGENCY) means an accidental traumatic bodily injury or other medical condition that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected, by a prudent layperson who possesses an average knowledge of health and medicine, to result in:

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 SERVICES means a medical screening examination, as required by federal law, that is within the capability of the Emergency department of a Hospital, including ancillary Services, and any trauma and burn center, routinely available to the Emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient.

EMPLOYEE means a regular, Full-Time Employee who is Actively at Work for the minimum number of hours Your Employer requires and who receives a W-2, but does not include volunteers or others who are not on the Employer's payroll.

EMPLOYER means Your Employer, who is the Policyholder named on the Master Group Policy issued by AultCare Insurance Company.

ENROLLEE (MEMBER) means You and Your Eligible Dependents who are Covered under the Master Group Policy.

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.

ENROLLMENT PERIODS means those times the Employer designates when an Eligible Person may Enroll to become a Covered Person in the Certificate by completing an Enrollment Form.

ERISA means the Employee Retirement Income Security Act of 1974, which establishes federal requirements for Group Health Plan Coverage.

ESSENTIAL HEALTH BENEFITS includes Benefits in at least the following categories: ambulatory patient Services; Emergency Services; Hospitalization; maternity and Newborn care; mental health and substance use disorder Services, including behavioral health treatment; prescription drugs; disease management; and pediatric Services, including dental and vision care.

EXCLUSION means a procedure, condition or Service that AultCare does not Cover or provide Benefits. Exclusions appear in this document and in the Benefits Chart.

EXPEDITED REVIEW means a review conducted no later than 72 hours after being assigned to an Independent Review Organization which is initiated for any of the following reasons:

A. Your treating Physician certifies that a Denial of Coverage involves a medical condition that could seriously jeopardize Your life or health if treated after the timeframe of an Expedited Review and You have filed a request for an Expedited Internal Review;

B. Your treating Physician certifies that a Denial of Coverage involves a medical condition that could seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function if treated after the timeframe of a standard External Review;

C. A Denial of Coverage concerns an admission, availability of care, continued stay, or Health Care service for which You received Emergency Services, but You have not yet been Discharged from a Facility.

EXPERIMENTAL OR INVESTIGATIONAL

A Health Care Service (including a supply, device, drug, and dental service) is Experimental or Investigational if We determine that any of the following apply:

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

- Approval is required by the U. S. Food and Drug Administration (FDA), or other licensing or regulatory agency, for marketing or use and final approval has not been granted; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that the Services is experimental or investigational, or for research purposes; or
- The Services is a type of drug, device, procedure, or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility or Provider, or the protocol or protocols of any other facility or Provider studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or Provider or by another facility or Provider studying the same drug, device, procedure, or treatment, states that the drug, device, procedure or treatment is experimental or investigational, or for research purposes; or
- We otherwise determine a Service is Experimental or Investigational based on Our consideration of scientific evidence, evidence of population health outcomes, effectiveness of established alternative Services, published and peer-reviewed medical or scientific literature, evaluations of medical associations, consensus panels, or technology evaluation bodies, documents issued by or filed with regulatory agencies, written protocol(s) used by Providers, medical records, opinions of consulting Providers, or other relevant information.

We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Service is Experimental or Investigative.

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

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

FACILITY (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 Employee and for the Eligible Dependents, including Spouse and Dependent Children.

FAMILY AND MEDICAL LEAVE ACT (FMLA) is a federal law that applies to certain Employers, which allows certain Employees to take up to 12 work weeks of unpaid, job-protected leave a year and requires that group health Benefits may be maintained during the leave, provided requirements are met.

FRAUD means the intentional action by an applicant or Enrollee (Member) to defraud or knowingly mislead by providing false or deceptive statements.

FULL-TIME EMPLOYEE means a permanent Employee Actively at Work who is regularly performing the minimum number of hours established by the Employer. A volunteer or one who does not receive a W-2 cannot qualify as a Full-Time Employee.

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

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).

GUARANTEED RENEWABILITY applies to Ohio "Small Employers," who are guaranteed the ability to renew Coverage under the Master Group Policy, subject to certain exceptions.

GROUP POLICY HOLDER means the Employer providing Benefits to its Employees and their Dependents.

HABILITATIVE SERVICES AND DEVICES means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

HIPAA (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 Health Care Operations.

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

HOME CARE (**HOME HEALTH CARE)** 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.

HOME HEALTH CARE 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 CMS or by an authority deemed by CMS to be an accredited authority, including but not limited to The Joint Commission, the American Osteopathic Association, and DNV Healthcare, Inc., (or any successor organization) as a Hospital that meets the requirements of 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. Generally have a life expectancy of 6 months or less.

C. 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 period.

INDEPENDENT REVIEW ORGANIZATION means a person or entity that conducts an External Review when a Claim has been denied.

INDIVIDUAL COVERAGE means Health Care Coverage only for the individual Employee and not for the Employee's Eligible Dependents.

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

INTENTIONAL MISREPRESENTATION means the providing of false or misleading information with the intent to defraud.

INTERNAL REVIEW means a review conducted by AultCare when a Covered Person requests a review because a Claim has been denied.

LEAVE OF ABSENCE means a period of time that one must be away from one's primary job, while maintaining the status of employee.

LEGAL CUSTODY means a legal status by a court that vests in You the right to have physical care and control of the Child and to determine where and with whom the Child shall live, and the right and duty to protect, train, and discipline the Child and to provide the Child with food, shelter, education, and medical care; and a Child who is Dependent on You for principal support according to IRS Dependency Guidelines and You Claim the Child on Your taxes.

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.

LIMITATIONS mean care, Services or supplies that are only eligible for Coverage and payment of Benefits up to the Plan's maximums. These are listed in this document and in the Benefits Chart.

LIMITING AGE means the age in which a person no longer is eligible as a Dependent. For Dependent Children the Limiting Age is 26.

MAINTENANCE CARE means care which is 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.

MASTECTOMY means the surgical removal of the entire breast, usually to treat serious breast disease, such as breast cancer.

MASTER GROUP POLICY means the insurance policy between the Employer and AultCare Insurance Company, which is affiliated with AultCare.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

A Health Care Service (including a supply, device, drug, and dental service) is Medically Necessary only if it is determined by Us to be:

- **A.** For the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease, or the symptom of an illness, injury or disease;
- **B.** Obtained from a Provider;
- **C.** Provided in accordance with accepted standards of medical or dental practice;
- **D.** Clinically appropriate, in terms of type, frequency, supply, extent, Site of Care and duration of the Service as determined in accordance with Our therapeutic and Site of Care guidelines;
- **E.** Not primarily for the convenience of the patient or Provider;
- **F.** Cost effective as compared to alternative Services or sequences of Services that are at least as likely to produce the same therapeutic or diagnostic results;
- **G.** Not Experimental or Investigational or Unproven; and
- **H.** Not otherwise subject to an exclusion under this Plan.

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

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

MEDICAL NUTRITION THERAPY means Nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional…" (source Medicare MNT legislation, 2000). MNT is a specific application of the Nutrition Care Process in clinical settings that is focused on the management of diseases. MNT involves in-depth individualized nutrition assessment and a duration and frequency of care using the Nutrition Care Process to manage disease.

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.

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.

NETWORK PROVIDER means a licensed Health Care provider operating within the scope of his or her license with whom AultCare has a contract for Services that generally are paid at a higher Benefit Level.

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.

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 Network.

NURSE means a graduate Nurse other than You, Your Dependent or Member of the immediate family. Nurse includes Registered Nurses and Licensed Practical Nurses.

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 VISIT means receiving medical or health care services in a Provider's private office.

OHIO DEPARTMENT OF INSURANCE (ODI) is a regulatory agency of the State of Ohio that is responsible for regulating insurance.

OPEN ENROLLMENT PERIOD means that time when the Employer annually permits Eligible Persons to submit Enrollment Forms to become new Covered Persons.

ORTHOTICS A support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body. They must restore function. To be Covered, Orthotics must meet the same requirements as Durable Medical Equipment.

OUT-OF-POCKET EXPENSES mean that portion of a bill or Claim that You are required to pay. These expenses include Copayments, Deductibles, and Coinsurance.

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

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.

PHYSICAL THERAPIST means a licensed Health Care professional who treats physical dysfunction or injury by the use of therapeutic exercise and the application of modalities, intended to restore or facilitate normal function or development.

PHYSICIAN means a Doctor of medicine, Doctor of osteopathic medicine, or podiatric Physician who is licensed by the Medical Board of the State of Ohio.

PLACEMENT FOR ADOPTION means the assumption and retention by a person of a legal obligation for total or partial support of a Child in anticipation of the adoption of the Child. The Child's placement with a person terminates upon the Termination of that legal obligation.

PLAN means a health Benefit Plan of insurance that offers health Coverage and Benefits. The Master Group Policy is the Plan between Your Employer and AultCare Insurance Company.

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

PODIATRIST means a Doctor of podiatric medicine who is licensed by the Medical Board of the State of Ohio.

PRE-APPROVAL (**PRIOR 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.

PREMIUM means a regular payment that We establish to pay for Coverage under the Master Group Policy, which Your Employer pays if the Plan is **NON-CONTRIBUTORY**, and which You and Your Employer may pay if the Plan is **CONTRIBUTORY**.

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, including recommended Preventive Services that are required to be covered without cost sharing under federal law. Recommended Preventive Services can be found at www.healthcare.gov.

PREVENTIVE SERVICES NUTRITIONAL COUNSELING means Counseling services provided to prevent obesity in children and to prevent cardiovascular disease in adults with cardiovascular risk factors. A supportive process to set priorities, establish goals, and create individualized action plans which acknowledge and foster responsibility for self-care.

PRIMARY PLAN means the Health Care Plan that first must pay Claims when Benefits are being coordinated under Coordination of Benefits.

PRIVATE DUTY NURSE means skilled nursing care ordered by a Physician that is provided to an individual on an Outpatient basis.

PROSPECTIVE REVIEW DETERMINATION (PRE-SERVICE) means a determination by our Utilization Management Department that is conducted before admission or the beginning of a course of treatment.

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.

PROTECTED HEALTH INFORMATION (PHI) means Protected Health Information, which includes personally identifiable information related to a 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.

PROVIDER means a licensed Physician or other Health Care Provider who furnishes medical or health care services that may be Covered under the Master Group Policy. See Network Provider and Non-Network Provider.

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. The Provider Directory can be found on the AultCare website at www.aultcare.com.

QUALIFIED MEDICAL CHILD SUPPORT ORDER means a formal order issued in or after divorce proceedings that may create or specifically recognize the right of a Child to be covered under the Plan.

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.

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.

REFERENCE BASED PRICE (RBP): "RBP" means the allowable fees for Covered Services. For Non-Network Providers, RBP means a fee level assigned based on a percentage of the allowed amount that Medicare would pay for the Covered Service or, if there is no corresponding Medicare rate for the Covered Service, a fee level that We have determined to be appropriate for the particular Covered Service, which often is less than the amount Providers actually charge. We will not pay that portion of the Non-Network Provider fees that exceed RBP. You may be responsible for paying that amount.

REFERRAL means that a Doctor 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.

REGISTERED NURSE means a Nurse licensed by the State Nursing Board.

REINSTATEMENT means that Coverage under the Master Group Policy, which lapsed or was interrupted, may be resumed under certain circumstances, if You return to being Actively at Work full time.

RESCISSION of Your Coverage means that the Coverage may be legally voided back to the day the Plan began to provide You with Coverage, just as if You never had Coverage under the Plan. Your Coverage can only be rescinded if You (or a person seeking Coverage on Your behalf) performs an act, practice, or omission that constitutes Fraud; or unless You (or a person seeking Coverage on Your behalf) makes an Intentional Misrepresentation of material fact, as prohibited by the terms of Your Plan.

RESPIRATORY THERAPIST means a licensed Health Care professional who provides respiratory care Services to individuals with disorders and diseases to the cardiopulmonary system.

RETIREMENT means an Employee who, generally because of age, no longer works Full-Time or at all. Generally, persons who go into Retirement are no longer Eligible for Coverage under the Master Group Policy.

RETROSPECTIVE REVIEW means utilization review of Medical Necessity that is conducted after health care services have been provided to the patient.

ROUTINE PATIENT CARE DURING A CLINICAL TRIAL means all health care services consistent with the Coverage provided in the Plan for the treatment of cancer or another life-threatening disease or condition.

This does not mean Coverage for the following:

- Cost of investigational items, devices, or Services.
- Costs associated with items and Services for the sole purpose of satisfying data collection and analysis needs and that are not used in direct clinical management.
- Costs for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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.

SECONDARY PLAN means the Health Care Plan that may have responsibility to pay Claims after the Primary Plan pays in a Coordination of Benefits situation.

SEMI-PRIVATE means the most common Semi-Private room rate at the Hospital.

SERVICES (HEALTH SERVICES) means the health care services and supplies Covered under the Certificate and Benefits Chart, except to the extent that such health care services and supplies are limited or excluded under the Certificate.

SICKNESS means illness, bodily disorder or disease, or 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. Complications of pregnancy mean concurrent disease or abnormal conditions which affect in a major way the usual medical management of pregnancy.

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

SKILLED NURSING FACILITY 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/behavioral health illness, alcohol/substance abuse, and pulmonary tuberculosis.

SMALL EMPLOYER is defined by Ohio law to mean an Employer who employs between 1-100 Employees.

SPEECH THERAPIST means someone who:

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

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

SPOUSE means husband or wife in a legal marriage.

STABILIZE means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

A. Placing the health of the covered person 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.

In the case of a woman having contractions, stabilize means such medical treatment as may be necessary to deliver, including the placenta.

STEPCHILD means a Child of the Spouse's previous marriage or union who has not been legally adopted by You.

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.

TELEMEDICINE - means a mode of providing health care services through synchronous or asynchronous information and communication technology by a health care professional, including interactive audio, video and other electronic media, within the professional's scope of practice, who is located at a site other than the site where the recipient is located.

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.

TERMINATION means the end of Your Coverage under a health plan.

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

THERAPY SERVICES means
services and supplies that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed in the "Covered Services" section.

TOTAL DISABILITY (TOTALLY DISABLED) means:

A. With respect to You, the first 365 days, or the period covered under the Master Group 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 days, 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.

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 Your Employer or Us because of a change in Eligibility, Coverage, or other circumstances that may affect Coverage and Benefits.

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

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

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

URGENT CARE 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.

USERRA means the Uniformed Services Employment and Re-Employment Rights Act of 1994. It is a federal law that permits a limited Continuation of Coverage up to 24 months if You are called up for military duty.

UTILIZATION MANAGEMENT (UTILIZATION 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.

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 Employee and his or her Eligible Dependents.

Section 37 – HIPAA PORTABILITY

HIPAA, which is short for the Health Insurance Portability and Accountability Act of 1996, is a federal law that protects health insurance Coverage for workers and their families when they want to add new Dependents in a special enrollment or when they change or lose their job.

Special Enrollment

Special enrollment means that You and Your Dependents who are eligible for special enrollment may sign up for health Coverage without having to wait for Your Group Health Plan to have Open Enrollment. If You or Your Eligible Dependents have special enrollment rights, You and they may enroll for health Coverage, even if Your Group Health Plan does not have Open Enrollment.

You may be eligible for special enrollment if You gain a new Dependent by marriage, birth, adoption, or Placement for Adoption. For example, You may be eligible for special enrollment if:

A. You previously turned down Coverage through Your Employer's Group Health Plan, but just got married and want to enroll both Yourself and Your new Spouse.

B. You are covered by Your Employer's Group Health Plan and want to enroll Your new baby.

C. You are covered by Your Employer's Group Health Plan and want to enroll Your Spouse and Your newly Adopted Child

D. You previously turned down Coverage through Your Employer's Group Health Plan, but You just had a baby and now want to enroll Yourself, Your Spouse, and Your new baby in Your health Plan.

If one of these events occurs, You need to request special enrollment by contacting Your Employer within 31 calendar days from the date You gain a new Dependent.

If You become eligible for or lose Medicaid or State Children's Health Insurance Program (SCHIP), You need to request special enrollment by contacting Your Employer within 60 days from the date of Eligibility or Termination per Children's Health Insurance Program Reauthorization Act of 2009.

You may choose from the Group Health Plans Your Employer offers during special enrollment.

If You request special enrollment in a timely manner because of a new Child, Coverage for Your Newborn or newly Adopted Child begins from the moment of that Child's birth, or date of adoption, or Placement for Adoption.

Section 38 – RESPONSIBILITIES AND RIGHTS UNDER ERISA AND OTHER FEDERAL LAW (IF APPLICABLE)

Your Employer and the Plan must comply with other federal laws, including the Employee Retirement Income Security Act of 1974, as amended, which sometimes is known as "ERISA."

Your Employer may have given You a booklet called a Summary Plan Description or "SPD," which describes Your ERISA responsibilities and rights, as well as Your rights and responsibilities under other federal law. In some cases, this Evidence of Coverage booklet serves that purpose. We want You to know Your responsibilities and rights. Please read this Statement in connection with this booklet and Your Benefits Chart.

A. Continuation of Coverage Rights

1. Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")

   In the event participation in a health Benefit offered through this Plan would otherwise terminate, a former Covered Person may have the right to continue health insurance Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or similar state or federal law. The Employer provides information about Coverage Continuation rights in the applicable Component Documents. A former Covered Person who is eligible to, and elects to, continue Coverage under the applicable Coverage Continuation law, may continue to participate in this Plan to the extent provided under the Coverage Continuation law. The applicable Component Documents may also describe terms and conditions of COBRA Continuation Coverage.

2. FMLA

   In the event participation in a health Benefit offered through this Plan would terminate due to the Eligible Employee taking an FMLA leave of absence (if applicable), Benefits may be continued for the lesser of: the period of the leave or 12 weeks. Coverage will continue only as long as any required Employee Contributions are timely made. Employees on leave must make the same Contribution as is required for Employees Actively at Work. Coverage under other welfare Benefits (other than health Benefits) may continue or terminate during a period of FMLA leave to the same extent as such Benefits continue or terminate during periods of leave under similar circumstances (that is, paid or unpaid leave, as the case may be) that is not FMLA leave.

3. USERRA

   In the event participation in health Benefits offered through this Plan would terminate due to the Eligible Employee taking a leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as modified by the Veterans' Benefits Improvement Act of 2004, such Benefits may be continued for the lesser of: the period of leave or 24 months. Coverage will continue only as long as any required Employee Contributions are timely made.

   Employees on a USERRA leave of less than 31 calendar days must make the same Contribution as is required for active Employees; Employees on a USERRA leave of 31 calendar days or longer must pay up to 102% of the full cost (Employee and Employer Contributions) of Coverage, as determined by the Plan Administrator.

B. Qualified Medical Child Support Orders

For purposes of this Section, a "Qualified Medical Child Support Order" is an order issued by a court having proper jurisdiction, or issued under an administrative process established under state law that has the force and effect of law under applicable state law and which creates or recognizes the existence of a Child's rights

to, or assigns to such Child the right to, receive health Benefits for which a Dependent is eligible under this Plan, provided such order clearly specifies: (1) the name and last known mailing address of the Employee, and the name and mailing address of each Child covered by the order (to the extent provided in the order, the name and mailing address of an official of the state agency issuing the order may be substituted for the name and mailing address of the Child); (2) a reasonable description of the type of Coverage to be provided by the Plan to each Child, or the manner in which Coverage is to be determined; (3) the time period to which such order applies; and (4) the Plan's name, and meets other legal requirements. A national medical support notice that meets (or, pursuant to federal regulations, is deemed to meet) the foregoing requirements will be considered a Qualified Medical Child Support Order.

The Plan will honor the terms of a Qualified Medical Child Support Order. Qualified Medical Child Support Orders are typically issued in or after divorce proceedings and may create or recognize the right of a Child to be covered under this Plan.

Medical Child support orders will be evaluated by the Plan Administrator or such other person or entity specified in the applicable Component Documents and shall be approved or denied. The Plan Administrator (or such other person or entity specified) shall, promptly after receiving a medical Child support order, notify the Participant and each Child designated in the order. The notification will contain information that permits the Child to designate a representative for receipt of copies of notices that are sent to the Child with respect to a medical Child support order.

Within 40 Business Days after receipt of the order (or, in the case a national medical support notice, the date of the notice) the Plan Administrator (or such other person or entity specified) will determine whether the order is a "qualified" medical Child support order. Upon determination of whether a medical Child support order is or is not qualified, the Plan Administrator (or such other person or entity specified) will send a written copy of the determination to the Participant and each Child (or, where an official of the state agency issuing the order is substituted for the name of the Child, notify such official).

If the Plan Administrator (or such other person or entity specified) determines that the medical Child support order is qualified, the Participant, the Child or his representative must furnish to the Plan Administrator or its designee any required enrollment information. In the case of a national medical support notice, the Plan Administrator or its designee will: (1) notify the state agency issuing the notice whether Coverage is available to the Child under the Plan and, if so, whether such Child is covered under the Plan and either the effective date of such Coverage or any steps to be taken by the Child's Custodial parent or an official of the state agency that issued the notice to effectuate such Coverage, and (2) provide the Custodial parent (or, where an official of the state agency issuing the order is substituted for the name of the Child, notify such official) a description of the Coverage available and any forms or documents necessary to effectuate such Coverage.

Typically, the Participant must provide such information to the Plan within 45 calendar days immediately following the date the determination was made that the order is a Qualified Medical Child Support Order. In the case of a national medical support notice, if there are multiple Coverage options available to the Child under the Plan the state agency issuing the notice will select an option, but if it fails to do so within 20 calendar days after the Plan Administrator's (or designee's) notice described in the preceding paragraph, the Child will be enrolled under the Plan's default option (if any).

Unless the Qualified Medical Child Support Order provides otherwise, the Participant will be responsible to make any required Contribution to pay for such Coverage. In no event will Coverage provided under a

Qualified Medical Child Support Order become effective for a Child prior to the date the Order is received by the Plan.

If the Plan Administrator or its designee determines that the medical Child support order is not "qualified," a written determination to that effect will be furnished to the Participant and the Child or the Child's representative. The Participant or the Child (or the Child's representative) may Appeal the determination to the Plan Administrator or its designee. Any request for review of a determination must be filed with the Plan Administrator or its designee within 60 calendar days after the Plan Administrator or its designee issues its original determination.

C. Claims Procedure under the Department of Labor Regulations

A Covered Person shall apply for Plan Benefits in writing on a form provided by the Plan Administrator or its delegate, unless a Claim is filed directly by a Provider of Benefits; provided that a Covered Person shall apply for Benefits on a form provided by an insurance company, if a Component Document so provides. A Claim for reimbursement of expenses must be submitted in a manner and within the time period specified in the applicable Component Documents. Claims shall be evaluated by the Plan Administrator or such other person or entity specified in the applicable Component Documents and shall be approved or denied in accordance with the terms of the Plan including the Component Documents.

The following Claims procedures shall apply (effective with respect to Claims received on or after the first day of Plan Year beginning after June 30, 2002; for Claims received prior to such date the rules of Department of Labor regulation § 2560.503-1 as in effect prior to that date shall control), but only to the extent not otherwise provided under the applicable Component Document, provided that such Component Document complies with the requirements of applicable law. If the Claim and Appeal rules in this document apply, they shall be construed and applied in a manner consistent with Department of Labor regulation § 2560.503-1 as in effect on the date the Claim was received:

1. Notice of Action

   Any time a Claim for Benefits receives an Adverse Determination (that is, the Claim is denied in whole or in part), the Employee or beneficiary ("Claimant") shall be given written notice of such action within the "applicable period" after the Claim is filed, unless special circumstances require an extension of time for processing. If there is an extension, the Claimant shall be notified of the extension and the reason for the extension within the initial applicable period. If any Urgent Care or Pre-Service Claim is approved, the Claimant shall be notified of such approval and provided sufficient information to understand the import of the approval.

2. Categories of Claims, Applicable Periods, and Extensions

   Health Care Claims include Claims for medical, dental, vision care, prescription drug Claims, and Claims under a Health Care flexible spending account.

   a. Urgent Health Care Claims

      Urgent Health Care Claims are requests for verification or approval of Coverage for medical, dental or vision care or treatment where, if the request were not handled expeditiously the delay

could jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to *severe pain* that cannot be adequately managed without the care or treatment that is the subject of the Claim.

The "applicable period" for an Urgent Care Claim is no longer than the period necessary to decide the matter (that is, "as soon as possible"), but in no event longer than 72 hours. If the Plan cannot render a decision within 72 hours because the Claimant has not provided sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan, the Plan Administrator or its delegate must notify the Claimant within 24 hours of the specific information needed to complete the Claim. The Claimant must be given at least 48 hours to provide the required information.

Within 48 hours after the earlier of (a) the Plan's receiving the required information or (b) the expiration of the period afforded to the Claimant to provide the information, the Plan Administrator or its delegate must notify the Claimant of the Plan's Benefit determination. The Claimant may agree to extend these deadlines.

An Appeal of an Adverse Determination regarding an urgent care Claim (where the Claim is still an Urgent Care Claim) must be decided as soon as possible, but no later than 72 hours after the Plan receives the request for review or Appeal.

b. Pre-Service Health Care Claims

A Pre-Service Health Care Claim is any request for approval of Coverage for medical, dental or vision care or treatment for a Service or item that under the terms of the Plan requires advance approval. The "applicable period" for a Pre-Service Claim is 15 calendar days after receipt of the Claim by the Plan. The Plan Administrator may extend the review period for an additional 15 calendar days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator or its delegate must notify the Claimant within the timeframe of the reason for the extension and the date the Plan expects to render its decision.

If the Claimant has not followed the Plan's procedures for filing a Pre-Service Claim, the Plan must notify the Claimant within 5 calendar days of the proper procedures to be followed in order to complete the Claim. Further, if the Plan cannot render a decision within 15 calendar days because the Claimant has not provided sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the Claim; the Claimant must be given at least 45 calendar days from receipt of the notice to provide the required information; and the Plan has 15 calendar days from the date of receiving the Claimant's information to render its decision. The Claimant may agree to extend these deadlines.

c. Concurrent Health Care Claims

A concurrent Health Care Claim may be either an Urgent Care Claim or a Pre-Service Claim. Generally, it is a Claim for an ongoing course of medical, dental or vision care or treatment to be provided over a period of time or number of treatments. An Adverse Determination involving

concurrent care must be made sufficiently in advance of any reduction or Termination in treatment to allow the Covered Person to Appeal the adverse Benefit determination. If a course of treatment involves Urgent Care, a request by the Claimant to extend the course of treatment must be decided as soon as possible, but not later than 24 hours after receipt of the request by the Plan, provided that the request is made at least 24 hours prior to the expiration of treatment.

Expiration of an approved course of treatment is not an Adverse Determination under these rules. However, any reduction or Termination by the Plan of the course of treatment (other than by Plan amendment or Termination) before the end of the period of time or number of treatments originally prescribed is an Adverse Determination and may be Appealed. Notice must be provided a reasonable time before the treatments will stop; however, the Plan is not required to allow the Claimant the 180 days to Appeal the Plan's decision, before the Plan may terminate the treatment.

d. "Post-Service" Health Care Claim

A post-Service Health Care Claim is a medical, dental or vision care Claim that is not an Urgent Care, Pre-Service or concurrent care Claim. The "applicable period" for a post-Service Claim is 30 days after receipt of the Claim by the Plan. The Plan Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator or its delegate must notify the Claimant within the timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

If the Plan cannot render a decision within 30 days because the Claimant has not provided sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the Claim. The Claimant must be given at least 45 days from receipt of the notice to provide the required information. The Plan has 30 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree to extend these deadlines.

e. Other Claims

If the Plan includes Benefits other than Health Care, medical, dental, vision or Disability, the "applicable period" for a Benefit Claims not described in subsections above is 90 days after receipt of the Claim by the Plan. If the Plan requires additional time to process the Claim, it may extend the applicable period by up to 90 days, but the Plan Administrator or its delegate must notify the Claimant of the need for the extension prior to the beginning of any such extension period.

3. Form and Content of Notice of Adverse Determination on Claims

If a Claim is denied in whole or in part, notice of such Adverse Determination must be provided to the Claimant. Notice must be written or electronic; oral notice is permitted with respect to Urgent Care Claims, but only if written or electronic confirmation is furnished to the Claimant within 3 days after the oral notice is provided.

The notice must include the following:

a. The specific reason or reasons for the Adverse Determination;

b. Reference to the specific Plan provisions on which the determination is based;

c. A description of any additional information needed for the Claimant to perfect the Claim, and an explanation of why such information is needed;

d. A description of the Plan's review procedures, including the Claimant's right to bring a civil action under Section 502(a) of ERISA;

e. A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the Adverse Determination or a statement that it will be provided without charge upon request (for Health Care and Disability Claims);

f. With respect to Health Care and Disability Claims, if the Adverse Determination is based on medical necessity or Experimental treatment or a similar Exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and

g. In the case of an Adverse Determination involving Urgent Care, a description of the Expedited Review process available to such Claims.

4. Right to Request Review

Any person, who has had a Claim for Benefits denied in whole or in part by the Plan Administrator or its delegate, or is otherwise adversely affected by action of the Plan Administrator or its delegate, shall have the right to request review by the Plan Administrator. Such request must be in writing, and must be made within 180 days (for Health Care and Disability Benefit Claims) or 60 days (for other Claims) after such person is advised of the Plan Administrator's (or its delegate's) action. If written request for review is not made within such 180-day (or 60-day, as the case may be) period, the Claimant shall forfeit his or her right to review. The Claimant or a duly authorized representative of the Claimant may review all pertinent documents and submit issues and comments in writing. The Plan Administrator may prescribe a reasonable procedure under which a Claimant may designate an authorized representative.

5. Review of Claim

The Plan Administrator or its delegate shall then review the Claim. The person or entity that reviews the Claim must be a named fiduciary under the Plan and (in the case of reviews of Health Care or Disability Claims) must not be the same person or a person subordinate to the person, who initially decided the Claim. If in the case of a Health Care or Disability Claim the adverse Benefit determination was based on medical judgment, the person handling the Appeal must consult with a Health Care professional with an appropriate level of training and expertise in the field of medicine involved, and such professional may not be the same professional who was consulted with respect to the initial action on the Claim.

The person or entity deciding the Appeal may hold a hearing if it deems it necessary and shall issue a written or electronically disseminated decision reaffirming, modifying or setting aside its former action. The decision on Appeal must be made within 72 hours for a Claim involving urgent Health Care, 30 days for a Pre-Service Health Care Claim, 45 days for a Disability Claim, or 60 days for a post-Service Health Care Claim or Claim for a Benefit other than a Health Care or Disability Benefit; the time period begins to run on the date the Appeal is received by the Plan. The Claimant may agree to extend these deadlines.

The decision on review may be delayed for up to 45 days (in the case of a Disability Benefit Claim) or 60 days (in the case of a Claim other than for a Health Care or Disability Benefit) where special circumstances require the delay. The Plan Administrator or its delegate shall provide notice of the extension, and the reason therefore, to the Claimant prior to the end of the initial review period.

A copy of the decision shall be furnished to the Claimant. The decision shall set forth the following:

a. The specific reason or reasons for the Adverse Determination;

b. Reference to the specific Plan provisions on which the determination is based;

c. A statement that the Claimant is entitled to receive without charge reasonable access to any document relied on in making the determination; submitted, considered or generated in the course of making the Benefit determination; that demonstrates compliance with the administrative processes and safeguards required in making the determination; or, in the case of a Group Health Plan or Disability Plan, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;

d. A statement of any voluntary Appeals procedures and the Claimant's right to receive information about the procedures as well as the Claimant's right to bring a civil action under Section 502(a) of ERISA;

e. A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the Adverse Determination or a statement that it will be provided without charge upon request;

f. If the Adverse Determination is based on medical necessity or Experimental treatment or a similar Exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and

g. The statement: "You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency."

The decision shall be final and binding upon the Claimant and all other persons involved.

D. Statement of ERISA Rights

Covered Persons' Rights

As an Eligible Employee covered under the Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all covered Eligible Employees shall be entitled to:

1. Receive Information About Your Plan and Benefits

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

c. Receive a summary of the Plan's annual financial report. The Plan Administrator is normally required by law to furnish each participant with a copy of this summary annual report.

2. Continue Group Health Plan Coverage

Continue Health Care Coverage for Yourself, covered Spouse or other Dependents if there is a loss of Coverage under the Plan as a result of a qualifying event. You or Your Covered Dependents may have to pay for such Coverage. Review this document and the Component Documents for the rules governing Your COBRA Continuation Coverage rights.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for covered Eligible Employees, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Covered Persons. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare Benefit or exercising Your rights under ERISA.

4. Enforce Your Rights

a. If Your Claim for a welfare Benefit is denied in whole or in part You must receive a written explanation of the reason for the Denial. You have the right to have the Plan review and reconsider Your Claim. Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

b. If You have a Claim for Benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your Claim is frivolous.

5. Assistance with Your Questions

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

Section 39 – Miscellaneous

A. Lawsuits

No lawsuits may be brought to recover on this Plan within sixty (60) days after written Proof of Loss has been given. No such lawsuit may be brought after three (3) years from the time written Proof of Loss is required to be given.

B. Statements

We will not use any statement, other than a fraudulent misstatement, by You to contest a claim after Your coverage has been effect continuously for two (2) years. If a claim is contested, a copy of such statement will be furnished to You or Your beneficiary. All Statements, in the absence of fraud, shall be deemed representations, not warranties, and no such statement shall avoid the insurance or reduce benefits unless contained in a written application.

C. Conformity of State Laws

Any provision of this Policy in conflict with the laws of the State in which it is delivered, is amended to conform to the minimum requirements of those laws.

D. Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage

validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, AultCare retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of an Insured Person, if it is requested, the amount of overpayment will be deducted from future benefits payable.

In the event of a clerical error, payment will be final after two years.

E. Physical Examination and Autopsy

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

F. Notice of Claim

Notice of claim. Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

Notice given by or on behalf of the insured or the beneficiary to the insurer at: (or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.)

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

Section 40 – Important Telephone Numbers and Addresses

If You have a question, problem, or Complaint, please call the AultCare 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. For members outside Stark County, You may also call Our toll-free number 1-800-344-8858.

You can also contact 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 330-438-9804. You can write Us at:

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

If You write, please list Your Employer, Group Number, and AultCare ID Number in Your letter. This information is on Your AultCare card. If You call, please have Your current AultCare card in front of You.

The address for the Ohio Department of Insurance is:

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

Section 41-Ohio Life and Health Insurance Guaranty Association Notice

The Ohio Life and Health Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. Coverage is NOT provided for Your policy or any portion of it that is not guaranteed by the insurer or for which You have assumed the risk, such as a variable contract sold by prospectus. You should check with Your insurance company representative to determine if You are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send You this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce You to purchase any kind of insurance policy.

Ohio Life and Health Insurance Guaranty Association
5005 Horizons Drive, Suite 200
Columbus, Ohio 43220

Ohio Department of Insurance
50 W. Town Street
Third Floor, Suite 300
Columbus, Ohio 43215