

OHIO VALLEY MANOR, INC.
EMPLOYEE HEALTH & WELFARE PLAN
PLAN DOCUMENT
&
SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE:
SEPTEMBER 1, 2011

The logo for AULTRA features a stylized 'A' icon on the left, composed of three overlapping triangles. To the right of the icon, the word 'AULTRA' is written in a bold, uppercase, sans-serif font.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

THE PRESCRIPTION BENEFITS PROVIDED UNDER THE PLAN WILL DEPEND ON WHETHER PRESCRIPTIONS ARE FILLED BY A NETWORK PHARMACY OR NOT. A LIST OF NETWORK PHARMACIES CAN BE OBTAINED FROM THE PLAN ADMINISTRATOR FREE OF CHARGE.

PRESCRIPTION DRUG COPAYS DO NOT COUNT TOWARDS THE SATISFACTION OF THE MAJOR MEDICAL DEDUCTIBLE OR OUT-OF-POCKET MAXIMUM.

PRESCRIPTION DRUG COPAY

Drugs Purchased at a Pharmacy:

Generic Drugs \$15.00 Copay per prescription
Name Brand Drugs 40% of cost Copay per prescription

Note: If a Prescription Drug costs less than the applicable Generic or Name Brand Copay, the Copay will equal the cost of the drug.

Drugs Purchased through the Mail Order Service:

Generic Drugs \$30.00 Copay per prescription
Name Brand Drugs 40% of cost Copay per prescription

Note: If a Prescription Drug costs less than the applicable Generic or Name Brand Copay, the Copay will equal the cost of the drug.

OVER-THE-COUNTER DRUG PROGRAM

This program allows for the purchase of OTC Proton Pump Inhibitor (PPI) and Non-Sedating Antihistamine (NSA), with a written prescription, with no copay charged to the Covered Person whether purchased through a retail or mail order pharmacy. The following is a list of Common PPI's and NSA's that potentially could be replaced, however, this list is not all-inclusive and is subject to change based on FDA regulated decisions and classifications.

PPI's: Aciphex, Nexium, Prilosec, Prevacid, Omeprazole, Protonix
PPI OTC: Prilosec OTC

NSA's: Allegra, Allegra-D, Clarenex, Zyrtec, Zyrtec-D, Claritin
NSA OTC: Loratidine, Claritin, Claritin D, Zyrtec, Zyrtec-D

DISPENSING LIMITS

Drugs purchased at a Pharmacy: Up to a 34-day supply, when used as prescribed.

Drugs purchased through the Mail Order Service: Up to a 90-day supply, when used as prescribed.

NETWORK BENEFITS

Prescription drugs, which are obtained through a Network Pharmacy or through the Mail Order Service, will be paid at 100% after the applicable prescription Copay.

NON-NETWORK BENEFITS

Prescription drugs obtained through a pharmacy, which is not part of the Prescription Drug Network, will not be considered an eligible benefit.

EMERGENCY SERVICES

If a medical Emergency occurs either within the area covered by or outside the area covered by the Prescription Drug Network, the benefit paid will be the same as if the prescription were filled by a Network Pharmacy. (Please check the definition of Emergency under the section entitled "Description of Prescription Drug Benefits".)

Health Care Reform

In response to the Patient Protection and Affordable Care Act, the following medications will be covered at a \$0.00 co-payment when the specific criteria listed below is met. You must obtain a written prescription from your physician to receive this benefit.

Category	Criteria	Co-payment
Low Dose Aspirin 81 mg	Males age 45 and over Females age 55 and over	\$0.00
Iron Supplementation	Through age 1 year	\$0.00
Oral Fluorides	Age 6 months up to 6 years	\$0.00
Folic Acid	Women up to age 55	\$0.00
Tobacco Cessation	Limit of 2 cycles of treatment (12 weeks per cycle)	\$0.00

SCHEDULE OF DENTAL BENEFITS

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

Dental Care coinsurance and maximums as listed, are separate and in addition to any other payment percentages or maximums under any other provisions of this Plan.

MAXIMUM BENEFIT

Maximum Calendar Year Benefit per Person for Class I, II, and III Services Combined	\$1,000
Maximum Lifetime Benefit per Person for Orthodontia (for Covered Dependents up to age 19).....	\$1,000

DEDUCTIBLE AMOUNTS

Preventive Services:	None
Basic Services, Major Services and Orthodontia Care:	
Each Person, Each Calendar Year	\$25
Maximum per Family per Calendar Year.....	\$50

COINSURANCE

Subject to Reasonable and Customary Fees

Preventive Services.....	100%
Basic Services	80%
Major Services	80%
Orthodontia Care (for Covered Dependents up to age 19).....	60%

SCHEDULE OF MEDICAL BENEFITS

BENEFITS MAY BE LIMITED FOR PRE-EXISTING CONDITIONS. PLEASE SEE THE SECTION ENTITLED "PRE-EXISTING CONDITIONS" FOR FURTHER INFORMATION.

THE BENEFITS SHOWN IN THIS SCHEDULE FOR HOSPITALIZATIONS AND SURGERIES MAY BE REDUCED IF A PERSON DOES NOT CONTACT AULTRA ADMINISTRATIVE GROUP AS SPECIFIED UNDER THE PLAN. PLEASE SEE THE SECTION ENTITLED "COST CONTAINMENT" FOR FURTHER INFORMATION.

COMBINED NETWORK AND NON-NETWORK MAXIMUMS

Individual **ANNUAL** Maximum for ALL Benefits.....\$2,000,000

DEDUCTIBLE AMOUNTS EACH CALENDAR YEAR

NETWORK DEDUCTIBLE AMOUNTS EACH CALENDAR YEAR:

Each Person\$1,000
Each Family.....\$3,000

(Example: 4 family members each have Network expenses of \$985, \$890, \$700 and \$425 during a Calendar Year for a total of \$3,000. No further Network deductible is then required for any other Family member during the Calendar Year.)

NON-NETWORK DEDUCTIBLE AMOUNTS EACH CALENDAR YEAR:

Each Person\$2,000
Each Family.....\$8,000

(Example: 4 family members each have Non-Network expenses of \$2,450, \$2,800, \$1,850 and \$900 during a Calendar Year for a total of \$8,000. No further deductible is then required for any other Family member during the Calendar Year.)

NETWORK AND NON-NETWORK DEDUCTIBLES EACH CALENDAR YEAR: When *BOTH* Network and Non-Network providers are utilized by a Covered Person during any Calendar Year, the Calendar Year Deductible will not exceed the Non-Network Calendar Year Deductible. Expenses applied to the Network Calendar Year Deductible will also apply toward the satisfaction of the Non-Network Calendar Year Deductible; expenses applied to the Non-Network Calendar Year Deductible will also apply toward the satisfaction of the Network Calendar Year Deductible.

Amounts a person must pay for the following expenses *will not* count towards satisfaction of the Calendar Year Deductible:

1. Expenses which are not eligible under the Plan; or
2. Reductions in Covered charges which must be paid by a Covered Person due to failure to pre-certify a Hospital admission or In-patient surgery; or
3. All Copays, including Prescription Drug Copays.

NETWORK PHYSICIAN OFFICE COPAY

Each time a Network Physician charges for an office visit, it is subject to an Office Visit Copay. This is the amount that must be paid by the Covered Person before any benefits are payable by the Plan.

Copay for Physician's charge for an Office Visit.....\$25.00 unless otherwise stated

Network Physician Office Visit Copays do not apply towards the satisfaction of an individual's or Family's Out-of-Pocket Maximum.

COINSURANCE (PERCENTAGE PAID)

EXCEPT WHERE OTHERWISE SHOWN, EXCLUDED OR LIMITED, ALL BENEFITS WILL BE PAID ON A REASONABLE & CUSTOMARY BASIS AT THE FOLLOWING PERCENTAGE LEVELS:

	<u>NETWORK</u>	<u>NON-NETWORK</u>
Coinsurance Percentage	80%/20%	60%/40%

OUT-OF-POCKET MAXIMUM EACH CALENDAR YEAR

	<u>NETWORK</u>	<u>NON-NETWORK</u>
Maximum Individual Out-of-Pocket Expense (INCLUDES the Deductible):	\$4,000	\$8,000
Maximum Family Out-of-Pocket Expense (INCLUDES the Deductible):	\$8,000	\$16,000

When *BOTH* Network and Non-Network providers are utilized by a Covered Person during any Calendar Year, the Out-of-Pocket Maximum will not exceed the Non-Network Out-of-Pocket Maximum. Network Out-of-Pocket Expenses will also apply toward the satisfaction of the Non-Network Out-of-Pocket Maximum. Non-Network Out-of-Pocket Expenses will also apply toward the satisfaction of the Network Out-of-Pocket Maximum.

Amounts a person must pay for the following expenses *will not* count towards the satisfaction of the Out-of-Pocket Maximum:

1. Expenses which are not eligible under the Plan; or
2. Reductions in Covered charges which must be paid by a Covered Person due to failure to pre-certify a Hospital admission or In-patient surgery; or
3. All Copays, including Prescription Drug Copays.

The benefits provided and percentage paid under the Plan will depend on whether services are received from a Network Provider or a Non-Network Provider. A list of the Network Providers can be obtained from the Plan Administrator free of charge.

	<u>NETWORK BENEFIT</u>	<u>NON-NETWORK BENEFIT</u>
SUPPLEMENTAL ACCIDENT	100%	100%
Copay Applies	No	No
Deductible Applies	No	No

Limited to the first \$300 of covered charges for medical care provided for an accidental Injury; and within 90 days after the date of the accident which caused the Injury. The limitation per accident is \$300 Network and \$300 Non-Network, charges are then payable subject to applicable deductible and coinsurance.

SECOND SURGICAL OPINION	100%	100%
Copay Applies	No	No
Deductible Applies	No	No

Maximum payable per visit.....\$200 Network and \$200 Non-Network.

WELL CHILD CARE (Birth up to 18 Years Old)	100%	60%
Copay Applies	No	No
Deductible Applies	No	Yes

Eligible charges for Well Child Care include, but are not limited to, the Physician's office visit charge and related tests, lab work, and immunizations. Immunizations received through the local health department are covered as if Network.

ROUTINE PHYSICAL (for Persons Age 18 and Older)	100%	60%
Copay Applies	No	No
Deductible Applies	No	Yes

Limited to one per Calendar Year. Eligible charges for Routine Physical include, the Physician's office visit charge and related lab work and x-rays.

ROUTINE IMMUNIZATIONS (for Persons Age 18 and Older)	100%	60%
Copay Applies	No	No
Deductible Applies	No	Yes

Immunizations received through the local health department are covered as if Network.

ROUTINE COLONOSCOPY	100%	60%
Copay Applies	No	No
Deductible Applies	No	Yes

Limited to age 50 and older, one routine colonoscopy every five (5) years.

ROUTINE COLORECTAL SCREENING	100%	60%
Copay Applies	No	No
Deductible Applies	No	Yes

Limited to one per Calendar Year.

	<u>NETWORK BENEFIT</u>	<u>NON-NETWORK BENEFIT</u>
ROUTINE MAMMOGRAM (for Persons Age 18 and Older)	100%	60%
Copay Applies	No	No
Deductible Applies	No	Yes

Limited to one per Calendar Year.

ROUTINE GYNECOLOGICAL EXAM AND PAP (for Persons Age 18 and Older)	100%	60%
Copay Applies	No	No
Deductible Applies	No	Yes

Exam is limited to one per Calendar Year. Eligible charges include the Physician's office visit charge and related lab work.

ROUTINE PROSTATE EXAM (for Persons Age 18 and Older)	100%	60%
Copay Applies	No	No
Deductible Applies	No	Yes

Limited to one per Calendar Year. Eligible charges include the Physician's office visit charge and related lab work.

SMOKING CESSATION (Counseling Only)	100%	Not Covered
Copay Applies	No	
Deductible Applies	No	

PHYSICIAN'S CHARGES FOR OFFICE VISIT	100%	60%
Copay Applies	Yes \$25	No
Deductible Applies	No	Yes

Copay applies to the office visit charge only and does not apply to other services received during the office visit. Only one office visit Copay will apply for services rendered in the Physician's office on the same day, regardless if an office visit is billed. Deductible and Coinsurance applies to surgical procedures.

PHYSICIAN'S CHARGES FOR SERVICES PROVIDED AT THE OFFICE	80%	60%
Copay Applies	No	No
Deductible Applies	Yes	Yes

DIAGNOSTIC X-RAY & LAB TESTS	80%	80%
Copay Applies	No	No
Deductible Applies	Yes	Yes (Network Deductible)

Eligible charges include services rendered during an office visit, outpatient or inpatient.

ALL OTHER PHYSICIAN CHARGES	80%	60%
Copay Applies	No	No
Deductible Applies	Yes	Yes

INPATIENT HOSPITAL CHARGES	80%	60%
Copay Applies	No	No
Deductible Applies	Yes	Yes

NETWORK BENEFIT

NON-NETWORK BENEFIT

**MEDICAL EMERGENCY CARE
IN A HOSPITAL EMERGENCY
ROOM (Life Threatening)**

	80%	80%
Copay Applies	Yes \$100	Yes \$100
Deductible Applies	Yes	Yes

Copay is waived if patient is admitted.

**NON-MEDICAL EMERGENCY
CARE IN A HOSPITAL
EMERGENCY ROOM**

	80%	80%
Copay Applies	Yes \$100	Yes \$100
Deductible Applies	Yes	Yes

Copay is waived if patient is admitted.

URGENT CARE FACILITY

	100%	60%
Copay Applies	Yes \$40	No
Deductible Applies	No	Yes

ANESTHESIA

	80%	80%
Copay Applies	No	No
Deductible Applies	Yes	Yes (Network Deductible)

HOME HEALTH CARE

	80%	60%
Copay Applies	No	No
Deductible Applies	Yes	Yes

Calendar Year Maximum..... Up to 30 Visits Network
and 30 Visits Non-Network.

Each visit by a home health aide of up to four consecutive hours in a 24-hour period
will be considered as one Home Health Care visit.

HOSPICE CARE

	80%	60%
Copay Applies	No	No
Deductible Applies	Yes	Yes

SKILLED NURSING FACILITY

	80%	60%
Copay Applies	No	No
Deductible Applies	Yes	Yes

Please refer to the section entitled "Description of Medical Benefits" for information
concerning the additional requirements, which must be satisfied in order for these
expenses to be eligible under the Plan.

AMBULANCE CHARGES

	80%	80%
Copay Applies	No	No
Deductible Applies	Yes	Yes

DURABLE MEDICAL EQUIPMENT

	80%	60%
Copay Applies	No	No
Deductible Applies	Yes	Yes

Orthotics are covered when prescribed by a Physician.

	<u>NETWORK BENEFIT</u>	<u>NON-NETWORK BENEFIT</u>
INFERTILITY TREATMENT	80%	60%
Copay Applies	No	No
Deductible Applies	Yes	Yes
Calendar Year Maximum..... Up to \$2,000 Network and \$2,000 Non-Network.		
SPEECH THERAPY (Illness/Injury Related)	80%	60%
Copay Applies	No	No
Deductible Applies	Yes	Yes
Calendar Year Maximum..... Up to 20 Visits Network and 20 Visits Non-Network.		
PHYSICAL/OCCUPATIONAL THERAPY	80%	60%
Copay Applies	No	No
Deductible Applies	Yes	Yes
Calendar Year Maximum..... Up to 30 Visits Network and 30 Visits Non-Network.		
CHARGES MADE BY A CHIROPRACTOR	80%	80%
Copay Applies	No	No
Deductible Applies	Yes	Yes (Network Deductible)
Calendar Year Maximum..... Up to 10 Visits Network and 10 Visits Non-Network		
Covered charges include those made by a chiropractor for office visits, treatments and related x-rays.		
ALL OTHER COVERED CHARGES	80%	60%
Copay Applies	No	No
Deductible Applies	Yes	Yes
INPATIENT TREATMENT OF ALCOHOL AND/OR DRUG ABUSE, MENTAL AND/OR NERVOUS DISORDERS	80%	60%
Deductible Applies	Yes	Yes
OUTPATIENT TREATMENT OF ALCOHOL AND/OR DRUG ABUSE, MENTAL AND/OR NERVOUS DISORDERS	80%	60%
Deductible Applies	Yes	Yes