STATE OF OHIO - OHIO MED PLAN
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Group Number
228000

PPO Network Comprehensive Major Medical Health Care Benefit Book

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PPO NETWORK COMPREHENSIVE MAJOR MEDICAL SCHEDULE OF BENEFITS

Benefit Period	July 1 to June 30
PPO Network Deductible per Benefit Period	$200 single / $400 family
Non-PPO Network Deductible per Benefit Period	$400 single / $800 family
Dependent Age Limit	The end of the month of the 26th birthday if he or she meets the requirements of an Eligible Dependent. See "Eligiblity" for optional extension to age 28.
Coinsurance Limit	$1,300 single / $2,600 family (amount excludes Deductible)
Non-PPO Network Coinsurance Limit	$2,600 single / $5,200 family (amount excludes Deductible)
PPO Network Out-of-Pocket Maximum per Benefit Period	$1,500 single / $3,000 family The Out-of-Pocket Maximum includes the amount of PPO Network Deductible expense, PPO Network Coinsurance expense and specified Copayment expense Incurred each Benefit Period
Non-PPO Network Out-of-Pocket Maximum per Benefit Period	$3,000 single / $6,000 family The Out-of-Pocket Maximum includes the amount of Non-PPO Network Deductible expense, Non-PPO Network Coinsurance expense and specified Copayment expense Incurred each Benefit Period

Any amounts applied to your PPO Network Deductible or PPO Network Coinsurance Limit will also be applied to your Non-PPO Network Deductible or Non-PPO Network Coinsurance Limit. Any amounts applied to your Non-PPO Network Deductible or Non-PPO Network Coinsurance Limit will also be applied to your PPO Network Deductible or PPO Network Coinsurance Limit.

Any Excess Charges you pay for claims will not accumulate towards the PPO Network Coinsurance Limits or towards the Non-PPO Network Coinsurance Limits.

Covered Services that require a Copayment are not subject to the Benefit Period Deductible Provisions, unless specified.

It is important that you understand how the Claims Administrator, Medical Mutual, calculates your responsibilities under this Benefit Book. Please consult the "HOW CLAIMS ARE PAID" section for necessary information.

To receive maximum benefits you must use PPO Network Providers. PPO Network Providers may change. Medical Mutual will tell you 60 days before a PPO Network Hospital becomes Non-PPO Network.

Remember, in an emergency, always go to the nearest appropriate medical facility; your benefits will not be reduced if you go to a Non-PPO Network Hospital in an emergency.

BENEFIT PERIOD MAXIMUMS PER COVERED PERSON	
Home Health Care Services	180 days or 100 visits, whichever is greater
Outpatient Nutritional Counseling Services mandated by federal law	Two visits
Outpatient Nutritional Counseling Services not mandated by federal law	Two visits
Routine Chest X-Ray, Complete Blood Count (CBC), Comprehensive Metabolic Panel, Electrocardiogram (EKG), and Urinalysis (UA)	One each
Routine Examinations associated with a PAP Test	One examination
Routine Physical Examinations received from a PPO Network Provider	One examination
Routine Physical Examinations received from a Non-PPO Network Provider for Covered Persons Age 40 to Age 59	One examination every two Benefit Periods; limited to a maximum of $150
Routine Physical Examinations received from a Non-PPO Network Provider for Covered Persons Age 60 and Older	One examination; limited to a maximum of $150

PREVENTIVE CARE SERVICES		
BENEFITS	**For Covered Services received from a PPO Network Provider, you pay the following portion based on Lesser Amount**	**For Covered Services received from a Non-PPO Network or Non-Contracting Provider, you pay the following portion based on Lesser Amount or Covered Charges**
ROUTINE SERVICES		
Well Child Care Immunizations and Laboratory Services • To age 21	0%, not subject to the Deductible	40%, subject to the Deductible
Well Child Care Office Visits • To age 21	0%, not subject to the Deductible	$30 Copayment, then 40% (4)
Cholesterol, Hemoglobin and Hematocrit	0%, not subject to the Deductible	0%
Complete Blood Count (CBC), Comprehensive Metabolic Panel, Urinalysis (UA) • Ages 21 and over	0%, not subject to the Deductible	0%
Blood Glucose Test	0%, not subject to the Deductible	0%
Fecal Occult Blood Test	0%, not subject to the Deductible	0%
Human Papillomavirus (HPV) Test	0%, not subject to the Deductible	0%
Venipuncture	0%, not subject to the Deductible	0%
Routine Outpatient Endoscopic Procedures: Colonoscopy, Sigmoidoscopy, Anoscopy and Proctosigmoidoscopy only	0%, not subject to the Deductible (5)	40%, subject to the Deductible
Routine PAP Tests	0%, not subject to the Deductible	40%, subject to the Deductible
Routine Mammogram (limited to first mammogram) • Ages 35 and over	0%, not subject to the Deductible (2)	40%, subject to the Deductible (2)
Routine Annual Physical Examinations	0%, not subject to the Deductible	$30 Copayment, then 0% (4)
Routine Prostate Specific Antigen (PSA) Test (limited to the first PSA Test) • Ages 40 and over	0%, not subject to the Deductible	40%, subject to the Deductible
Routine Immunizations (Non-Well Child) Covered for All Ages, except as specified in the Routine and Wellness Section • Hemophilis Influenza B (HEPB-HIB) • Hepatitis A,B, A & B and hepatitis b • Human Papillomavirus vaccine (HPV) • Influenza (received in other than a Pharmacy) • Measles • Measles and Rubella • Mumps • MMR (measles, mumps and rubella) • Meningococcal vaccine • Pneumonia • Pneumococcal Conjugate vaccine • Polio • Rotavirus (Rota) (under age 21) • Rubella • Tetanus Toxoid • Tetanus, Diptheria, Pertussis (Td/Tdap) • Dipththeria, Tetanus, Pertussis (DTaP) • Varicella (VSV) • Zoster (age 19 and older)	0%, not subject to the Deductible	40%, subject to the Deductible
Other Preventive Services in accordance with state and federal law	0%, not subject to the Deductible	40%, subject to the Deductible

COINSURANCE PAYMENTS	Institutional and Professional Charges	Institutional and Professional Charges
TYPE OF SERVICE	**For Covered Services received from a PPO Network Provider, you pay the following portion based on Lesser Amount**	**For Covered Services received from a Non-PPO Network or Non-Contracting Provider, you pay the following portion based on Lesser Amount or Covered Charges**
EMERGENCY SERVICES		
Emergency - Emergency Room and Emergency Services - the Institutional charge for use of the Emergency Room and all other related Institutional charges	$75 Copayment, waived if admitted, then 20%, subject to the Deductible (1)	$75 Copayment, waived if admitted, then 20%, subject to the Deductible (1)
Emergency Services - all other related Professional charges	20%, subject to the Deductible	20%, subject to the Deductible
Non-Emergency - Emergency Room and Non-Emergency Services - the Institutional charge for use of the Emergency Room and all other related Institutional charges	$75 Copayment, waived if admitted, then 20%, subject to the Deductible (1)	$75 Copayment, waived if admitted, then 40%, subject to the Deductible (1)
Non-Emergency Services - all other related Professional charges	20%, subject to the Deductible	40%, subject to the Deductible
AUDIOLOGY/HEARING SERVICES		
Assessment for Hearing Aids	$20 Copayment, then 0% (4)	$30 Copayment, then 40% (4)
Hearing Evaluations/Examinations	20%, subject to the Deductible	40%, subject to the Deductible
Hearing Services - All Other Covered Services as a result of Natural Causes (not an Accident or Illness - $1000 lifetime limit)	50%, subject to the Deductible	50%, subject to the Deductible
Hearing Services - All Other Covered Services as a result of an Accidental Injury or Illness	20%, subject to the Deductible	40%, subject to the Deductible
HEALTH EDUCATION AND TRAINING SERVICES		
Outpatient Diabetic Education and Training Services	20%, not subject to the Deductible	40%, subject to the Deductible
Outpatient Education and Training for Obesity Services	20%, not subject to the Deductible	40%, subject to the Deductible
Outpatient Nutritional Counseling Services mandated by federal law (limited to two visits)	0%, not subject to the Deductible	40%, subject to the Deductible
Outpatient Nutritional Counseling Services not mandated by federal law (limited to two visits)	20%, not subject to the Deductible	40%, subject to the Deductible
INPATIENT SERVICES		
Initial Newborn Examination	0%, not subject to the Deductible	0%, not subject to the Deductible
Semi-Private Room and Board	20%, subject to the Deductible	40%, subject to the Deductible
Skilled Nursing Facility Services • Up to 180 days per admission	20%, not subject to the Deductible	20%, not subject to the Deductible
Skilled Nursing Facility Services • After 180 days per admission	40%, not subject to the Deductible	40%, not subject to the Deductible
MAMMOGRAM SERVICES		
Medically Necessary Mammograms • To age 35 • Ages 35 and older (after the first Mammogram)	20%, subject to the Deductible (2)	40%, subject to the Deductible (2)
Medically Necessary Mammograms (limited to the first Mammogram) • Ages 35 and older	0%, not subject to the Deductible (2)	40%, subject to the Deductible (2)
PHYSICIAN/OFFICE SERVICES		
Immunizations - Medically Necessary	0%, not subject to the Deductible	40%, subject to the Deductible
Influenza Vaccines received in a Pharmacy	40%, subject to the Deductible	40%, subject to the Deductible

COINSURANCE PAYMENTS	Institutional and Professional Charges	Institutional and Professional Charges
TYPE OF SERVICE	**For Covered Services received from a PPO Network Provider, you pay the following portion based on Lesser Amount**	**For Covered Services received from a Non-PPO Network or Non-Contracting Provider, you pay the following portion based on Lesser Amount or Covered Charges**
Medically Necessary Office Visits	$20 Copayment, then 0% (3)(4)	$30 Copayment, then 40% (3)(4)
Office Visits for Obesity	20%, not subject to the Deductible	40%, subject to the Deductible
Prenatal Care and Antepartum Care Office Visits	0%, not subject to the Deductible	$30 Copayment, then 40% (4)
Urgent Care Provider Office Visits	$25 Copayment, then 0% (3)(4)	$30 Copayment, then 40% (3)(4)
Other Physician/Office Services (in an office or urgent care setting)	20%, subject to the Deductible	40%, subject to the Deductible
OTHER ROUTINE, WELLNESS AND PREVENTIVE SERVICES		
Routine Prostate Specific Antigen Test • To Age 40 • Ages 40 and older (after the first PSA Test)	20%, subject to the Deductible	40%, subject to the Deductible
Routine Therapeutic Injection Administration	0%, not subject to the Deductible	40%, subject to the Deductible
Routine X-ray, Laboratory and Medical Testing Services (Services not previously listed in Preventive Care Services)	20%, subject to the Deductible	40%, subject to the Deductible
Other Preventive Services in accordance with state and federal law	0%, not subject to the Deductible	40%, subject to the Deductible
SURGICAL SERVICES		
Inpatient and Outpatient Surgery	20%, subject to the Deductible	40%, subject to the Deductible
Medically Necessary Outpatient Endoscopic Procedures (i.e, Colonoscopy, Sigmoidoscopy, etc.)	20%, subject to the Deductible	40%, subject to the Deductible
OTHER SERVICES		
Ambulance Services	20%, not subject to the Deductible	20%, not subject to the Deductible
Durable Medical Equipment Services	20%, subject to the Deductible	40%, subject to the Deductible
Home Health Care Services	20%, subject to the Deductible	40%, subject to the Deductible
Hospice Services	0%, not subject to the Deductible	0%, not subject to the Deductible
Outpatient Occupational, Physical and Speech Therapy Services and Chiropractic Visits	20%, subject to the Deductible	40%, subject to the Deductible
All Other Covered Services	20%, subject to the Deductible	40%, subject to the Deductible

Notes

The Coinsurance percentage will be the same for Non-Contracting Providers as Non-PPO Network Providers but you may be subject to Balance Billing and/or Excess Charges. Payments to Contracting Non-PPO Network Providers are based on the Negotiated Amount. Payments to Non-Contracting Providers are based on the Non-Contracting Amount.

1. The Copayment you must pay for these Covered Services will accumulate towards the Coinsurance Limit and the Non-PPO Network Coinsurance Limit. **After the Coinsurance Limit and/or Non-PPO Network Coinsurance Limit is met, you will continue to be required to pay a Copayment for these Covered Services**.
2. Mammograms are limited to a maximum of 130% of the Medicare reimbursement amount for each mammogram.
3. If any of these Covered Services are received from the same Provider on the same day, only one Copayment will be charged per day.
4. The Copayment you must pay for these Covered Services will accumulate towards the Coinsurance Limit and the Non-PPO Network Coinsurance Limit. After the Coinsurance Limit and/or Non-PPO Network Coinsurance Limit is met, you will no longer be required to pay a Copayment for Covered Services.
5. If a diagnosis of a medical Condition is made during the screening (e.g., removal of a polyp), the procedure is no longer considered routine and may be considered a diagnostic procedure under Surgical Services.

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL HEALTH CARE BENEFIT BOOK

This Benefit Book describes the health care benefits available to you as a Covered Person in the Self-Funded Health Benefit Plan (the Plan) offered to you by your Employer (the Group).

There is an Administrative Services Agreement between Medical Mutual Services (Medical Mutual) and the Group pursuant to which Medical Mutual processes claims and performs certain other duties on behalf of the Group.

All persons who meet the following criteria are covered by the Plan and are referred to as **Covered Persons, you or your.** They must:

- pay for coverage if necessary; and
- satisfy the Eligibility conditions specified by the Group.

The Group and Medical Mutual shall have the exclusive right to interpret and apply the terms of this Benefit Book. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Medical Mutual and the Group, subject to any available appeal process.

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.

This Benefit Book should be read and re-read in its entirety. Many of the provisions of this Benefit Book are interrelated; therefore, reading just one or two provisions may not give you an accurate impression of your coverage.

Your Benefit Book may be modified by the attachment of Riders and/or amendments. Please read the provisions described in these documents to determine the way in which provisions in this Benefit Book may have been changed.

Many words used in this Benefit Book have special meanings. These words will appear capitalized and are defined for you in the Definitions section. By reviewing these definitions, you will have a clearer understanding of your Benefit Book.

HOW TO USE YOUR BENEFIT BOOK

This Benefit Book describes your health care benefits. Please read it carefully.

The **Schedule of Benefits** gives you information about the limits and maximums of your coverage and explains your Coinsurance, Copayment and Deductible obligations, if applicable.

The **Definitions** section will help you understand unfamiliar words and phrases. If a word or phrase starts with a capital letter, it is either a title or it has a special meaning. If the word or phrase has a special meaning, it will be defined in this section or where used in the Benefit Book.

The **Eligibility** section outlines how and when you and your dependents become eligible for coverage under the Plan and when this coverage starts.

The **Health Care Benefits** section explains your benefits and some of the limitations on the Covered Services available to you.

The **Exclusions** section lists services which are not covered in addition to those listed in the Health Care Benefits section.

The **General Provisions** section tells you how to file a claim and how claims are paid. It explains how Coordination of Benefits and Subrogation work. It also explains when your benefits may change, how and when your coverage stops and how to obtain coverage if this coverage stops.

DEFINITIONS

After Hours Care - services received in a Physician's office at times other than regularly scheduled office hours, including days when the office is normally closed (e.g., holidays or Sundays).

Agreement - the administrative services agreement between Medical Mutual and your Group. The Agreement includes the individual Enrollment Forms of the Card Holders, this Benefit Book, Schedules of Benefits and any Riders or addenda.

Balance Billing - The difference between a Provider's charge and the Plan's allowed amount for which Non-PPO Network and Non-Contracting Providers may bill.

Benefit Book - this document.

Benefit Period - the period of time specified in the Schedule of Benefits during which Covered Services are rendered, and benefit maximums, Deductibles, Coinsurance Limits and Non-PPO Network Coinsurance Limits are accumulated. The first and/or last Benefit Periods may be less than 12 months depending on the Effective Date and the date your coverage terminates.

Billed Charges - The amount billed on the claim submitted by the Provider for services and supplies provided to a Covered Person.

Card Holder - an Eligible Employee or member of the Group who has enrolled for coverage under the terms and conditions of the Plan and persons continuing coverage pursuant to COBRA or any other legally mandated continuation of coverage.

Charges - the Provider's list of charges for services and supplies before any adjustments for discounts, allowances, incentives or settlements. For a Contracting Hospital in the State of Ohio, charges are the master charge list uniformly applicable to all payors before any discounts, allowances, incentives or settlements.

Coinsurance - a percentage of the Lesser Amount for Contracting Institutional Providers and Physicians and Other Professional Providers or a percentage of the Non-Contracting Amount for Non-Contracting Institutional Providers for which you are responsible after you have met your Deductible or paid your Copayment.

Coinsurance Limit - a specified dollar amount of Coinsurance expense Incurred in a Benefit Period by a Covered Person for Covered Services received from a PPO Network Provider.

Condition - an injury, ailment, disease, illness or disorder.

Contraceptives - oral, injectable, implantable, transdermal patches or IUDs for birth control.

Contracting - the status of a Hospital or Other Facility Provider:

- that has an agreement with Medical Mutual or Medical Mutual's parent company about payment for Covered Services; or
- that is designated by Medical Mutual or its parent as Contracting.

Copayment - a dollar amount, if specified in the Schedule of Benefits, that you may be required to pay at the time Covered Services are rendered.

Covered Charges - The Billed Charges less non-covered items.

Covered Person - the Card Holder, and if family coverage is in force, the Card Holder's Eligible Dependent(s).

Covered Service - a Provider's service or supply as described in the Health Care Benefits section of this Benefit Book for which the Plan will provide benefits, as listed in the Schedule of Benefits.

Creditable Coverage - coverage of an individual under any of the following:

- a group health plan, including church and governmental plans;
- health insurance coverage;
- Part A or Part B of Title XVIII of the Social Security Act (Medicare);
- the health plan for active military personnel, including TRICARE;
- the Indian Health Service or other tribal organization program;
- a state health benefits risk pool;

- the Federal Employees Health Benefits Program;
- a public health plan as defined in federal regulations;
- a health benefit plan under section 5 (c) of the Peace Corps Act; or
- any other plan that provides comprehensive hospital, medical and surgical services.

Custodial Care - care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting his or her activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes but is not limited to:

- administration of medication which can be self-administered or administered by a lay person; or
- help in walking, bathing, dressing, feeding or the preparation of special diets.

Custodial Care does not include care provided for its therapeutic value in the treatment of a Condition.

Custodian - a person who, by court order, has custody of a child.

Deductible - an amount, usually stated in dollars, for which you are responsible each Benefit Period before the Plan will start to provide benefits.

Effective Date - 12:01 a.m. on the date when your coverage under the Plan begins, as determined by your Group.

Emergency - an accidental traumatic bodily injury or other medical Condition that arises suddenly and unexpectedly and 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:

- place an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

Emergency Admission - an Inpatient admission to a Hospital directly from a Hospital emergency room.

Emergency Care - Covered Services that are furnished by a Provider within the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

Emergency Services - a medical screening examination as required by Federal Law that is within the capability of the Emergency Department of the Hospital, including ancillary services routinely available to the Emergency Department to evaluate an Emergency medical Condition; and further medical examination and treatment that are required to Stabilize an Emergency medical Condition and within the capabilities of the staff and facilities available at the Hospital, including any trauma or burn center at the Hospital.

Enrollment Form - a form you get from your employer and complete for yourself and your Eligible Dependents to be considered for coverage under the Plan.

Essential Health Benefits - benefits defined under federal law (PPACA) as including 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; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Excess Charges - the amount of Billed Charges in excess of the covered Traditional Amount or Non-Contracting Amount determined payable by Medical Mutual for a Non-Contracting Institutional Provider, a Non-Participating Physician or Other Professional Provider.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure - a drug, device, medical treatment or procedure is Experimental or Investigational:

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials or is under study to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or

- if reliable evidence shows that the consensus of opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure. Determination will be made by Medical Mutual at its sole discretion and will be final and conclusive, subject to any available appeal process.

Federally Eligible Individual -

- an individual who has had an 18 month period of Creditable Coverage with final coverage through a group plan, governmental plan or church plan. Coverage, after which there was a break of more than 63 days does not count in the period of Creditable Coverage. Creditable Coverage will be counted based on the standard method without regard to specific benefits;
- an individual who must apply within 63 days of the end of the termination date of your coverage under the group policy;
- an individual must not be eligible for coverage under a group health plan, Medicare or Medicaid;
- an individual must not have other health insurance coverage;
- an individual whose most recent prior coverage has not been terminated for nonpayment of premium or fraud; and
- if the individual elected COBRA coverage or Ohio extension of benefits coverage, the individual must exhaust all such continuation coverage to become a Federally Eligible Individual. Termination for non-payment of premium does not constitute exhausting such coverage.

Group - the State of Ohio who entered into an Agreement with Medical Mutual for Medical Mutual to provide administrative services for the State of Ohio's health plan.

Hospital - an Institution that meets the specifications of Chapter 3727 of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio.

Immediate Family - the Card Holder and the Card Holder's spouse, parents, stepparents, grandparents, nieces, nephews, aunts, uncles, cousins, brothers, sisters, children and stepchildren by blood, marriage or adoption.

Incurred - rendered to you by a Provider. All services rendered by the Institutional Provider during an Inpatient admission prior to termination of coverage are considered to be Incurred on the date of admission.

Inpatient - a Covered Person who receives care as a registered bed patient in a Hospital or Other Facility Provider where a room and board charge is made.

Institution (Institutional) - a Hospital or Other Facility Provider.

Legal Guardian - an individual who is either the natural guardian of a child or who was appointed a guardian of a child in a legal proceeding by a court having the appropriate jurisdiction.

Lesser Amount - for Contracting and Participating Providers, the Lesser Amount means the Lesser of the Negotiated Amount or the Covered Charges. For Non-Participating Physicians and Other Professional Providers, the Lesser Amount means the lesser of the Billed Charges or Traditional Amount. For Non-Contracting Institutional Providers, the Lesser Amount means the Non-Contracting Amount.

Medical Care - professional services received from a Physician or an Other Professional Provider to treat a Condition.

Medically Necessary (or Medical Necessity) - a service, supply and/or Prescription Drug that is required to diagnose or treat a Condition and which Medical Mutual determines is:

- appropriate with regard to the standards of good medical practice and not Experimental or Investigational;
- not primarily for your convenience or the convenience of a Provider; and
- the most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or Condition require that the services cannot be safely or adequately provided to you as an Outpatient. When applied to Prescription Drugs, this means the Prescription Drug is cost effective compared to alternative Prescription Drugs which will produce comparable effective clinical results.

Medicare - the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare Approved - the status of a Provider that is certified by the United States Department of Health and Human Services to receive payment under Medicare.

Mental Illness - a Condition classified as a mental disorder in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, excluding Drug Abuse and Alcoholism and excluding Biologically Based Mental Illness.

Negotiated Amount - the amount the Provider has agreed with Medical Mutual to accept as payment in full for Covered Services.

The Negotiated Amount for Institutional Providers does not include adjustments and/or settlement due to prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim.

The Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings, volume based credits or refunds or discount guarantees.

The Negotiated Amount for Contracting Institutional Providers may exceed the Covered Charges.

The Negotiated Amount for Participating Physicians and Other Professional Providers does not include any performance withhold adjustments.

In certain circumstances, Medical Mutual may have an agreement or arrangement with a vendor who purchases the services, supplies or products from the Provider instead of Medical Mutual contracting directly with the Provider itself. In these circumstances, the Negotiated Amount will be based upon the agreement or arrangement Medical Mutual has with the vendor and not upon the vendor's actual negotiated price with the Provider, subject to the further conditions and limitations set forth herein.

Non-Contracting - the status of a Hospital or Other Facility Provider that does not meet the definition of a Contracting Institutional Provider.

Non-Contracting Amount - the maximum amount determined as payable and allowed by Medical Mutual for a Covered Service provided by a Non-Contracting Institutional Provider.

Non-Covered Charges - Billed Charges for services and supplies that are not Covered Services.

Non-Participating - the status of a Physician or Other Professional Provider that does not have an agreement with Medical Mutual about payment for Covered Services.

Non-PPO Network Coinsurance - a percentage of the Lesser Amount for Non-PPO Network Providers or the Covered Charges for Non-Contracting Institutional Providers for which you are responsible after you have met your Deductible or paid your Copayment, if applicable.

Non-PPO Network Coinsurance Limit - a specified dollar amount of Non-PPO Network Coinsurance expense for which you are responsible in each Benefit Period.

Non-PPO Network Deductible - an amount, usually stated in dollars, for which you are responsible each Benefit Period before the Plan will start to provide benefits for services received from a Non-PPO Network Provider.

Non-PPO Network Provider - a Physician or Other Professional Provider, Contracting Hospital or Contracting Other Facility Provider, Home Health Care Agency or Hospice Provider that is not designated by Medical Mutual as a PPO Network Provider.

Office Visit - Office visits include medical visits or Outpatient consultations in a Physician's office or patient's residence. A Physician's office can be defined as a medical/office building, Outpatient department of a Hospital, freestanding clinic facility or a Hospital-based Outpatient clinic facility.

Other Facility Provider - the following Institutions which are licensed, when required, and where Covered Services are rendered which require compensation from their patients. Other than incidentally, these facilities are not used as offices or clinics for the private practice of a Physician or Other Professional Provider. The Plan will only provide benefits for services or supplies for which a charge is made. Only the following Institutions which are defined below are considered to be Other Facility Providers:

- **Ambulatory Surgical Facility -** a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a Physician and also includes nursing services.

- **Dialysis Facility -** a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- **Home Health Care Agency -** a facility which meets the specifications of Chapter 3701.88 of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio and which provides nursing and other services as specified in the Home Health Care Services section of this Benefit Book. A Home Health Care Agency is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Hospice Facility -** a facility which provides supportive care for terminally ill patients as specified in the Hospice Services section of this Benefit Book.
- **Skilled Nursing Facility -** a facility which primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a Physician.

Other Professional Provider - only the following persons or entities which are licensed as required:

- advanced nurse practitioner (A.N.P.);
- ambulance services;
- dentist;
- doctor of chiropractic medicine;
- durable medical equipment or prosthetic appliance vendor;
- laboratory (must be Medicare Approved);
- licensed independent social workers (L.I.S.W.);
- licensed practical nurse (L.P.N.);
- licensed professional clinical counselor;
- licensed vocational nurse (L.V.N.);
- mechanotherapist (licensed or certified prior to November 3, 1975);
- nurse-midwife;
- occupational therapist;
- ophthalmologist;
- physical therapist;
- physician assistant;
- podiatrist;
- registered nurse (R.N.);
- registered nurse anesthetist; and
- Urgent Care Provider.

Out-of-Pocket Maximum - The maximum dollar amount you will have to pay for Covered Services under a health benefit plan before the Coinsurance percentage changes to 100 percent for the remainder of a given Benefit Period. Deductibles, Coinsurance and Copayments apply towards this maximum, unless otherwise specified on the Schedule of Benefits.

Outpatient - the status of a Covered Person who receives services or supplies through a Hospital, Other Facility Provider, Physician or Other Professional Provider while not confined as an Inpatient.

Participating - the status of a Physician or Other Professional Provider that has an agreement with Medical Mutual about payment for Covered Services.

Physician - a person who is licensed and legally authorized to practice medicine.

Plan - The program of health benefits coverage established by the Group for its employees or members and their Eligible Dependents.

PPO Network Deductible - an amount, usually stated in dollars, for which you are responsible each Benefit Period before the Plan will start to provide benefits for services received from a PPO Network Provider.

PPO Network Provider - a Physician, Other Professional Provider, Contracting Hospital or Contracting Other Facility Provider that is included in a limited panel of Providers as designated by Medical Mutual and for which the greatest benefit will be payable when one of these Providers is used.

Preadmission Certification Penalty - The amount you must pay for failing to obtain from Medical Mutual, preadmission certification for an Inpatient admission to a Hospital for other than an Emergency Admission.

Prescription Drug (Federal Legend Drug) - any medication that by federal or state law may not be dispensed without a Prescription Order.

Prescription Order - the request for medication by a Physician appropriately licensed to make such a request in the ordinary course of professional practice.

Professional Charges - The cost of a Physician or Other Professional Provider's services before the application of the Negotiated Amount.

Provider - a Hospital, Other Facility Provider, Physician or Other Professional Provider.

Residential Treatment Facility -

- A facility that provides care on a 24 hour a day, seven days a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders.
- The facility provides room and board as well as providing an individual treatment plan for the chemical, psychological and social needs of each of its residents.
- The facility meets all regional, state and federal licensing requirements.
- The residential care treatment program is supervised by a professional staff of qualified Physician(s), licensed nurses, counselors and social workers.
- Residents do not require care in an acute or more intensive medical setting.

Routine Services - Services not considered Medically Necessary.

Skilled Care - care that requires the skill, knowledge or training of a Physician or a:

- registered nurse;
- licensed practical nurse; or
- physical therapist

performing under the supervision of a Physician. In the absence of such care, the Covered Person's health would be seriously impaired. Such care cannot be taught to or administered by a lay person.

Stabilize - with respect to an Emergency Medical Condition, to provide such medical treatment of the Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the Condition is likely to result from or occur during the transfer of the individual from a facility.

Student - an Eligible Dependent who is enrolled full-time at an accredited institution of higher learning.

Surgery -

- the performance of generally accepted operative and other invasive procedures;
- the correction of fractures and dislocations;
- usual and related preoperative and postoperative care; or
- other procedures as reasonably approved by Medical Mutual.

Traditional Amount - the maximum amount determined and allowed by Medical Mutual for a Covered Service provided by a Physician or Other Professional Provider based on factors, including the following:

- the actual amount billed by a Provider for a given service
- Center for Medicare and Medicaid Services (CMS)'s Resource Based Relative Value Scale (RBRVS)
- other fee schedules
- input from Participating Physicians and wholesale prices (where applicable)
- geographic considerations; and
- other economic and statistical indicators and applicable conversion factors.

Transplant Center - a facility approved by Medical Mutual that is an integral part of a Hospital and which:

- has consistent, fair and practical criteria for selecting patients for transplants;
- has a written agreement with an organization that is legally authorized to obtain donor organs; and
- complies with all federal and state laws and regulations that apply to transplants covered under this Benefit Book.

United States - all the states, the District of Columbia, the Virgin Islands, Puerto Rico, American Samoa, Guam and the Northern Mariana Islands.

Urgent Care Provider - an Other Professional Provider that performs services for health problems that require immediate medical attention that are not Emergencies.

ELIGIBILITY

Enrolling for Coverage

Prior to receiving this Benefit Book, you enrolled, and were accepted or approved by your Group for individual coverage or family coverage. For either coverage, you may have enrolled online or completed an Enrollment Form. There may be occasions when the information on the Enrollment Form is not enough. The Group will then request the additional data needed to determine whether your dependents are Eligible Dependents.

Under individual coverage, only the Card Holder is covered. Under family coverage, the Card Holder and the Eligible Dependents who have been enrolled are covered.

Eligibility Requirements

Employee Eligibility

You are eligible for health care benefits if you are a permanent full-time or permanent part-time employee, which includes established-term regular, established-term irregular, a judge or other elected or appointed official.

State of Ohio employee health plans do not contain pre-existing condition exclusions; therefore, coverage is available to you and your eligible dependents regardless of current health or health history.

Married State Employees

When a husband and wife are both employed by the state, both employees cannot carry family coverage for medical, dental or vision. You have the following options:

- Both may carry single coverage
- Both may be covered by one family plan
- One employee may carry family coverage and the other single, but the spouse with single coverage may not be listed as a dependent under the family plan

Examples of Employees NOT Eligible for Coverage

- Temporary
- Seasonal
- Intermittent
- Interim
- Student or college intern

Dependent Eligibility

Family members as described below may be eligible for coverage under your medical coverage:
(Please go to: das.ohio.gov/eligibility requirements for the Definitions and Required Documents checklist for documentation required to enroll a dependent).

1. Spouse. Your current legal spouse as recognized by Ohio law.
2. Children under Age 26 including:
    - Your biological children (married or unmarried)
    - Your legally adopted children: adopted children have the same coverage as children born to you or your spouse, whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption.
    - Your dependent stepchildren
    - Foster children
    - Children for whom either you or your spouse has been appointed legal guardian
    - Children for whom the plan has received a Qualified Medical Child Support order: the child must be named as your alternate recipient in the QMCSO

Note: Dependent children are only eligible for dental/vision benefits if unmarried and under age 23. Dependent children ages 19-22 with dental/vision coverage must be a student.

3. Unmarried Children Incapable of Self-Care

   Unmarried children who are incapable of self-support due to mental retardation, severe mental illness, or physical handicap, whose disability began before age 26 and who are primarily dependent upon you are eligible for coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled for coverage, provided that the application is submitted within five (5) years following loss of coverage.

   This coverage is not automatic. You must complete the applicable form for this plan. The form can be found at das.ohio.gov/healthplanforms

   Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

4. HB1 Child

   Ohio House Bill 1 of the 128th General Assembly created a new category of eligibility for the state medical plan. HBI coverage is available for medical (including prescription drug and behavioral health) coverage only.

   HB1 Child requirements:

   - Your unmarried child, age 26 and 27; and
   - Child is your natural child, stepchild or adopted child; and
   - Child is a resident of Ohio or a full time student at an accredited public or private institution of higher education; and
   - Child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and
   - Child is not eligible for state Medicaid or federal Medicare

   A special rate applies for these children.

   You can enroll your HB1 Child with the Annual Affidavit of House Bill 1 Child.

   When you enroll your HB1 Child, you must indicate on the applicable form whether the child qualifies as an IRS tax dependent or a child (within the meaning of 26 USC 152(f)(1)) who has not attained age 27 as of the end of the taxable year. You may wish to consult with an independent tax advisor as to your HB1 child's status under the Internal Revenue Code and IRS regulations. If your HB1 child qualifies as an IRS tax dependent or as a child (within the meaning of 26 USC 152(f)(1)) who has not attained age 27 as of the end of the taxable year, the deduction for coverage will occur before adjusted gross income is calculated (pre-tax dollars). If your HB1 child does not meet one of these qualifications, the deduction for coverage will occur after adjusted gross income is calculated.

   An employee may enroll or disenroll an HB1 Child during open enrollment, when the child reaches the plan's limiting age, or when a child experiences a change in circumstances. Examples of a change in circumstance (Ohio Administrative Code 3901-8-13) include moving back to Ohio or the child's loss of employer-sponsored coverage.

   To enroll or disenroll an HB1 Child, the employee must notify their agency benefits specialist within 30 days of the change in circumstance. Upon receiving your request, your child will be offered the opportunity to enroll in HB1 coverage within thirty days. If eligible, coverage will be effective at the beginning of the plan year for open enrollment enrollees, and within 30 days of receiving notice of the election and the required documentation.

Examples of Persons NOT Eligible for Coverage as a Dependent:

- A spouse from whom the employee is legally divorced or legally separated
- Children who are age 28 and older
- A spouse or child currently in the military service, eligible for coverage under a federal health plan
- Same-sex partners
- Live-in boyfriends or girlfriends
- Parents or parents-in-law
- Grandchildren (unless employee is the court-appointed legal guardian)

- Adults who are not the employee's or spouse's child under guardianship of employee (brother, sister, aunt, uncle, etc.)
- A spouse from a common law marriage established in Ohio after October 10, 1991
- Any other members of your household who do not meet the definition of an eligible dependent

It is the employee's responsibility to disenroll a family member who is no longer eligible for coverage.

Knowingly providing false or misleading dependent eligibility information may result in any or all of the following actions by the State of Ohio: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible dependents; and/or 4) civil and/or criminal prosecution.

Child Support Order

In general, a medical child support order is a court order that requires an Eligible Employee to provide medical coverage for his or her children in situations involving divorce, legal separation or paternity dispute. A medical child support order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. This Plan provides benefits according to the requirements of a medical child support order that is entered by a court of competent jurisdiction or by a local child support enforcement agency. The Group will promptly notify affected Card Holders if a medical child support order is received. The Group will notify these individuals of its procedures for determining whether medical child support orders meet the requirements of the Plan; within a reasonable time after receipt of such order, the Group will determine whether the order is acceptable and notify each affected Card Holder and of its determination. Once the dependent child is enrolled under a medical child support order, the child's appointed guardian will receive a copy of all pertinent information provided to the Eligible Employee. In addition, should the Eligible Employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

Effective Date

Coverage starts at 12:01 a.m. on the Effective Date. The Effective Date is typically the first day of the month following your hire date. The effective date for enrollment or changes made during open enrollment is typically July 1. No benefits will be provided for services, supplies or charges Incurred before your Effective Date.

Changes in Coverage

If you have individual coverage, you may change to family coverage if you marry or you or your spouse acquire an Eligible Dependent. You must notify your benefits specialist who must then notify Medical Mutual of the change.

Coverage for a spouse and other dependents who become eligible by reason of marriage will be effective on the first of the month following the date of the marriage if a request for their coverage is submitted to the Group within 31 days of the marriage. A newborn child or an adopted child will be covered as of the date of birth or adoptive placement, provided that you request enrollment within 31 days of the date of birth or adoptive placement. Coverage will continue for an adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

It is important to complete and submit your Enrollment Form promptly.

There are occasions when circumstances change and only the Card Holder is eligible for coverage. Family coverage must then be changed to individual coverage. In addition, the Group must be notified when you or an Eligible Dependent under your Benefit Book becomes eligible for Medicare.

Special Enrollment

Under normal circumstances, you cannot change or drop your health benefits coverage unless you experience a qualifying event. Any changes outside of open enrollment must be in compliance with the applicable rules of the Internal Revenue Code Section 125 which may include but not be limited to the following:

1. After marriage, death of a spouse, divorce, legal separation, or annulment, in which case coverage becomes effective the first day of the month following the month of the event.
2. Birth, adoption, placement for adoption, or death of a dependent, in which case coverage becomes effective with the birth, adoption, or placement of a child or date of death.
3. Termination or commencement of employment by the employee, spouse or dependent, in which case coverage becomes effective the first day of the month following the month of the event.

4. Reduction or increase in hours of employment by the employee (including layoff or reinstatement from layoff), spouse, or dependent, including a switch between part-time and full-time, strike, lockout, or commencement, return to work from an unpaid absence, or change in work site in which case coverage becomes effective the first day of the month following the month of the event.
5. Return to work through order of arbitration or settlement of a grievance, or any administrative body with authority to order the return to work of an employee.
6. The employee's dependent satisfies or fails to satisfy the requirement of the definition of dependent due to attainment of age, student status or any similar circumstance as provided in the Health Plan under which the employee receives coverage
7. If the plan receives a Qualified Medical Child Support Order (QMCSO) pertaining to an employee's dependent, the employee may elect to add or drop the child to the plan depending upon the requirement of the QMCSO.
8. If an employee, spouse, or dependent who is enrolled in a health plan becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).
9. If an employee, spouse, or dependent is no longer entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

   Requests for changes pursuant to Sections (1) through (9) must be supported by proper documentation. Documentation must be submitted within 31 days of the event.

Your Identification Card

You will receive identification cards. These cards have the Card Holder's name and identification number on them. The identification card should be presented when receiving Covered Services under this coverage because it contains information you or your Provider will need when submitting a claim or making an inquiry. Your receipt or possession of an identification card does not mean that you are automatically entitled to benefits.

After coverage ends, use of the identification card is not permitted and may subject you to legal action.

HEALTH CARE BENEFITS

This section describes the services and supplies covered if provided and billed by Providers. All Covered Services must be Medically Necessary unless otherwise specified.

Please refer to the Pre-Authorization of Non-PPO Network Benefits in the How Claims Are Paid section of the General Provisions for information regarding services received from Non-PPO Network Providers.

Allergy Testing and Treatments

Allergy testing performed and related to a specific diagnosis is covered. Desensitization treatments and allergy injections are also covered.

Ambulance Services

Transportation services via ambulance must be certified by your Physician and are subject to medical review to determine Medical Necessity. Ambulance services include local ground transportation by a vehicle equipped and used only to transport the sick and injured:

- from your home, scene of an accident or medical Emergency to a Hospital;
- between Hospitals;
- between a Hospital and a Skilled Nursing Facility;
- from a Hospital or Skilled Nursing Facility to your home; or
- from a Physician's office to a Hospital.

Trips must be to the closest facility that is medically equipped to provide the Covered Services that are appropriate for your Condition.

Transportation will also be covered when provided by a professional ambulance service for other than local ground transportation only when special treatment is required and the transportation is to the nearest Hospital qualified to provide the special treatment.

Transportation services provided by an ambulette or a wheelchair van are not Covered Services.

Audiology Services

Benefits are provided for hearing examinations, fittings and hearing aids as well as conformity evaluations.

One of the following hearing aids will be covered:

- in-the-ear;
- behind-the-ear (including air conduction and bone conduction types);
- on-the-body.

It must be prescribed on the basis of the most recent Audiometric Examination and hearing aid evaluation test.

Conformity Evaluation is an evaluation of the performance of the prescribed hearing aid to determine the conformance of the hearing aid to the prescription.

These services must be provided by a Physician-Specialist or an Audiologist.

Case Management

Medical Mutual's case management staff evaluates opportunities to cover cost-effective alternatives to the patient's current health care needs. Case management has proven to be very effective with catastrophic cases and long-term care. In such instances, benefits not expressly covered in this Benefit Book may be approved. All case management programs are voluntary for the patient.

Coverage for these services must be approved in advance and in writing by Medical Mutual.

To learn more about these services, you may contact Medical Mutual's case management staff.

Clinical Trial Programs

Benefits are provided for routine patient care administered to a Covered Person participating in any stage of an eligible cancer clinical trial, if that care would be covered under the Plan if the Covered Person was not participating in a clinical trial.

"Eligible cancer clinical trial" means a cancer clinical trial that meets all of 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; and
- The trial does one of the following:
  - Tests how to administer a health care service, item, or drug 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 centers under the United States Department of Health and Human Services;
    - The United States Food and Drug Administration;
    - The United States Department of Defense; or
    - The United States Department of Veterans' Affairs.

"Routine patient care" means all health care services consistent with the coverage provided under the Plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.

"Subject of a cancer clinical trial" means the health care service, item, or drug that is being evaluated in the clinical trial and that is not routine patient care.

No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the cancer clinical trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; and
- A service, item, or drug that is eligible for reimbursement by a person other than Medical Mutual, including the sponsor of the cancer clinical trial.

Contraceptive Services

Your coverage includes benefits for the following contraceptive services:

- contraceptive devices, including but not limited to diaphragms and intrauterine devices (IUDs); and
- contraceptive implants, including Surgery for the insertion or removal of implantable contraceptives.

Oral, transdermal and injectable contraceptives are not covered.

Dental Services for an Accidental Injury

Dental services will only be covered for initial injuries sustained in an accident. The accidental injury must have caused damage to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an accidental injury.

Diagnostic Services

A diagnostic service is a test or procedure performed when you have specific symptoms, to detect or monitor your Condition. It must be ordered by a Physician or Other Professional Provider. Covered diagnostic services are limited to the following:

- radiology, ultrasound and nuclear medicine;
- laboratory and pathology services; and
- EKG, EEG, MRI and other electronic diagnostic medical procedures.

Drug Abuse and Alcoholism Services

Coverage is provided for psychological testing and health and behavior assessment/intervention services.

All other services are not covered by Medical Mutual. A comprehensive range of Drug Abuse and Alcoholism benefits are provided by the State of Ohio's mental health provider. Please refer to the phone number on your ID card.

Drugs and Biologicals

You are covered for Prescription Drugs and biologicals that cannot be self-administered and are furnished as part of a Physician's professional service, such as antibiotics, joint injections and chemotherapy, in the course of the diagnosis or treatment of a Condition. Other drugs that can be self-administered or that may be obtained under drug coverage, if applicable, are not covered but the administration of the drug may be covered.

Drugs that can be covered under your prescription drug plan need to be obtained under your Pharmacy coverage.

Durable Medical Equipment

Information regarding benefits for durable medical equipment (DME) is found under the "Medical Supplies and Durable Medical Equipment" section.

Emergency Care Services

You are covered for Medically Necessary Emergency Care following an Emergency. Chronic Conditions are not considered to be Emergencies unless an acute, life-threatening attack occurs. Emergency Care is available 24 hours a day, 7 days a week. If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital to obtain Emergency Services. **Care and treatment once you are Stabilized is not Emergency Care.** Continuation of care beyond that needed to evaluate or Stabilize your Condition in an Emergency will be covered according to your Schedule of Benefits. Please refer to your Schedule of Benefits for detailed coverage explanation.

Health Education Services

Benefits are provided for educational, vocational and training services while an Inpatient of a Hospital or Other Facility Provider.

Diabetic Education Services - Outpatient diabetic self-management training and education services are Covered Services when provided under the supervision of a licensed health care professional with expertise in diabetes. These services help to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diet and medical nutrition therapy.

Obesity Education Services - Outpatient Obesity education services are provided to Covered Persons with a diagnosis of obesity.

Home Health Care Services

The following are Covered Services when you receive them in your home, from a Hospital or a Home Health Care Agency:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- Prescription Drugs;
- oxygen and its administration;
- medical social services, such as the counseling of patients; and
- home health aide visits when you are also receiving covered nursing or therapy services.

The Plan will not cover any home health care services or supplies which are not specifically listed in this Home Health Care Services section. Examples include but are not limited to:

- homemaker services;
- food or home delivered meals; and
- Custodial Care, rest care or care which is only for someone's convenience.

All Home Health Care services must be certified initially by your Physician and your Physician must continue to certify that you are receiving Skilled Care and not Custodial Care as requested by the Plan. All services will be provided according to your Physician's treatment plan and as authorized as Medically Necessary by Medical Mutual Non-PPO Network Provider services must have prior approval.

Hospice Services

Hospice services consist of health care services provided to a terminally ill Covered Person. Hospice services must be provided through a freestanding Hospice Facility or a hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Covered Person in a private residence.

Benefits for hospice services are available when the prognosis of life expectancy is six months or less.

The following Covered Services are considered hospice services:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- Prescription Drugs; limited to a two-week supply per Prescription Order or refill (These Prescription Drugs must be required in order to relieve the symptoms of a Condition, or to provide supportive care.);
- oxygen and its administration;
- medical social services, such as the counseling of patients;
- home health aide visits when you are also receiving covered nursing or therapy services;
- acute Inpatient hospice services;
- respite care;
- dietary guidance; counseling and training needed for a proper dietary program;
- durable medical equipment; and
- bereavement counseling for family members.

Non-covered hospice services include but are not limited to:

- **volunteer services;**
- **spiritual counseling;**
- **homemaker services;**
- **food or home delivered meals;**
- **chemotherapy or radiation therapy if other than to relieve the symptoms of a Condition; and**
- **Custodial Care, rest care or care which is only for someone's convenience.**

Infertility Services

Benefits are available for diagnostic services to establish the cause or reason of the infertility and for certain Medically Necessary treatments of a Condition.

Non-covered services include, but are not limited to:

- **invitro fertilization**
- **artificial insemination**
- **GIFT**
- **ZIFT**
- **the following infertility injections:**
  - **metnotropins**
  - **follitropin alfa**
  - **follitropin beta**
  - **ganirelix acetate**
  - **human chorionic gonadotropin (HCG)**
  - **choriogonadotropin alfa**
  - **lutropin alfa**
  - **cetrorelix.**

Inpatient Hospital Services

You must have each Inpatient admission to a Non-PPO Network Hospital certified by Medical Mutual in order to receive the full benefits as specified in the Schedule of Benefits. If you have an Inpatient admission to a Non-PPO Network Hospital which is not precertified, you will be required to pay a Preadmission Certification Penalty of $350.

To obtain preadmission certification for an Inpatient admission, you must call the Medical Mutual case management staff at least two days prior to your admission to the Non-PPO Network Hospital. Refer to your identification card for the telephone number.

In the event of an Emergency Admission, you must notify the Medical Mutual case management staff within 48 hours or two working days of admission or the Preadmission Certification Penalty will apply.

The Preadmission Certification Penalty is in addition to specified Deductibles. The Preadmission Certification Penalty does not accumulate toward the Coinsurance Limit, nor does it change when the Coinsurance Limit is reached.

The Covered Services listed below are benefits when services are performed in an Inpatient setting, except as specified.

The following bed, board and general nursing services are covered:

- a semiprivate room or ward;
- a private room, when Medically Necessary; if you request a private room, Medical Mutual will provide benefits only for the Hospital's average semiprivate room rate; and
- a bed in a special care unit approved by Medical Mutual. The unit must have facilities, equipment and supportive services for the intensive care of critically ill patients.

Covered ancillary Hospital services include but are not limited to:

- operating, delivery and treatment rooms and equipment;
- Prescription Drugs;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing;
- anesthesia, anesthesia supplies and services;
- oxygen and other gases;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services;
- therapy services; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

Non-covered Hospital services include but are not limited to:

- gowns and slippers;
- shampoo, toothpaste, body lotions and hygiene packets;
- take-home drugs;
- telephone and television; and
- guest meals or gourmet menus.

Coverage is not provided for an Inpatient admission for which the primary purpose is:

- diagnostic services;
- Custodial Care;
- rest care;
- environmental change; or
- physical therapy.

Coverage for Inpatient care is not provided when the services could have been performed on an Outpatient basis, and it was not Medically Necessary for you to be an Inpatient to receive them.

Maternity Services

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy, miscarriage and routine nursery care for a well newborn are covered.

Coverage for the Inpatient postpartum stay for the mother and the newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a caesarean section. It will be for the length of stay recommended by the

American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care.

If requested by the mother, coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the attending Physician or the nurse midwife in applicable cases, determines further Inpatient postpartum care is not necessary for the mother or newborn child, provided the following are met:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:
  - the antepartum, intrapartum and postpartum course of the mother and infant;
  - the gestational stage, birth weight and clinical condition of the infant;
  - the demonstrated ability of the mother to care for the infant after discharge; and
  - the availability of postdischarge follow up to verify the condition of the infant after discharge.

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of Inpatient care required to be covered, at home post delivery follow up care visits are covered for you at your residence by a Physician or nurse when performed no later than 72 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

- parent education;
- physical assessments;
- assessment of the home support system;
- assistance and training in breast or bottle feeding; and
- performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At the mother's discretion, this visit may occur at the facility of the Provider.

Medical Care

Concurrent Care - You are covered for care by two or more Physicians during one Hospital stay when you have two or more unrelated Conditions. You are also covered for care for a medical Condition by a Physician who is not your surgeon while you are in the Hospital for Surgery.

Inpatient Medical Care Visits - The examinations given to you by your Physician or Other Professional Provider while you are in the Hospital are Covered Services. Benefits are provided for one visit each day you are an Inpatient.

If your Group changes your health care benefits, causing an increase or decrease in your Inpatient Medical Care Visits allowed, the number of Inpatient Medical Care Visits already used will be deducted from the number of visits available under your new coverage.

Inpatient Consultation - A bedside examination by another Physician or Other Professional Provider is covered when requested by your attending Physician.

If the consulting Physician takes charge of your care, consultation services are not covered. When this occurs, the consulting Physician is considered to be the new attending Physician. Coverage is not provided for both the new attending Physician and the Physician who was initially treating you for services rendered at the same time.

Staff consultations required by Hospital rules are not covered.

Intensive Medical Care - Constant medical attendance and treatment is covered when your Condition requires it.

Newborn Exam - Your coverage includes the Inpatient Medical Care Visits to examine a newborn. Refer to the Eligibility section for information about enrolling for family coverage.

Office Visits - Office visits to examine, diagnose and treat a Condition are Covered Services. In addition to the office visit charge, charges for care received after hours may also covered.

Medical Supplies and Durable Medical Equipment

This section describes supplies and equipment that are covered when prescribed by your Physician. These supplies and equipment must serve a specific therapeutic purpose in the treatment of a Condition.

Medical and Surgical Supplies - Disposable supplies which serve a specific therapeutic purpose are covered. These include:

- needles;
- oxygen;
- surgical dressings and other similar items;
- syringes.

Items usually stocked in the home for general use are not covered, these include but are not limited to:

- **corn and bunion pads;**
- **elastic bandages;**
- **Jobst stockings and support/compression stockings;**
- **thermometers.**

Durable Medical Equipment (DME) - Equipment which serves only a medical purpose and must be able to withstand repeated use is covered. Upon request, your Physician must provide a written treatment plan that shows how the prescribed equipment is Medically Necessary for the diagnosis or treatment of a Condition or how it will improve the function of a malfunctioning body part. If you need to use this equipment for more than six months, your Physician may be required to recertify that continued use is Medically Necessary.

You may rent or purchase DME; however, for each Condition, the Plan will not cover more in total rental costs than the customary purchase price as determined by Medical Mutual. When it has been determined that you require DME, before you decide whether to rent or purchase, estimate what the rental cost will be for the time period during which you will use the DME. If the estimated rental cost exceeds the purchase price, then you should consider purchasing the DME.

For example, if you submit claims for the monthly rental fee and by the third month the total in rental dollars meets or exceeds the customary purchase price, you will have exhausted your benefit for that piece of durable medical equipment.

Covered DME includes:

- crutches;
- home dialysis equipment;
- hospital beds;
- mastectomy bra;
- respirators;
- wheelchairs.

Non-covered equipment includes but is not limited to:

- **rental costs if you are in a facility which provides such equipment;**
- **repair costs which are more than the rental price of another unit for the estimated period of use, or more than the purchase price of a new unit;**
- **Physician's equipment, such as a blood pressure cuff or stethoscope;**
- **deluxe equipment such as specially designed wheelchairs for use in sporting events;**
- **items not primarily medical in nature such as:**
  - **an exercycle, treadmill, bidet toilet seat, elevator and chair lifts, lifts for vans for motorized wheelchairs and scooters;**
  - **items for comfort and convenience;**
  - **disposable supplies and hygienic equipment;**
  - **self-help devices such as: bedboards, bathtubs, sauna baths, overbed tables, adjustable beds, special mattresses, telephone arms, air conditioners and electric cooling units;**

- **Jobst stockings and other compression devices.**

Orthotic Devices - Rigid or semirigid supportive devices which limit or stop the motion of a weak or diseased body part are covered. These devices include:

- occlusal orthotic devices (covered for accidental injury in all cases or non-accidental injury when not covered under a dental plan);
- braces for the leg, arm, neck or back;
- foot orthotics after a diagnosis of diabetes;
- trusses;
- back and special surgical corsets.

Non-covered devices include but are not limited to:

- **garter belts, arch supports, corsets and corn and bunion pads;**
- **corrective shoes, except with accompanying orthopedic braces;**
- **arch supports and other foot care or foot support devices for other than diabetes. These include but are not limited to care for flat feet and subluxations, corns, bunions, calluses and toenails.**

Prosthetic Appliances - Your coverage includes the purchase, fitting, adjustments, repairs and replacements of prosthetic devices which are artificial substitutes and necessary supplies that:

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

Covered prosthetic appliances include:

- artificial hands, arms, feet, legs and eyes, including permanent lenses;
- appliances needed to effectively use artificial limbs or corrective braces.

Non-covered appliances include but are not limited to:

- **dentures, unless as a necessary part of a covered prosthesis;**
- **dental appliances, except as specified above;**
- **eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye;**
- **replacement of cataract lenses unless needed because of a lens prescription change;**
- **taxes included in the purchase of a covered prosthetic appliance;**
- **deluxe prosthetics that are specially designed for uses such as sporting events;**
- **wigs and hair pieces.**

Mental Health Care Services

Coverage is provided for psychological testing and health and behavior assessment/intervention services.

All other services are not covered by Medical Mutual. A comprehensive range of mental health benefits are provided by the State of Ohio's mental health provider. Please refer to the phone number on your ID card.

Organ and Tissue Transplant Services

Your coverage includes benefits for the following Medically Necessary human organ/tissue transplants:

- bone marrow;
- cornea;
- heart;
- heart and lung;
- kidney;

- liver;
- lung;
- pancreas; and
- pancreas and kidney

if such services take place during a transplant benefit period. A transplant benefit period is a period of time which starts five days before the day you receive your first covered transplant and ends 12 months later. A new transplant benefit period starts only if the next covered transplant occurs more than 12 months after the last covered transplant was performed. No transplant waiting periods and/or organ transplant maximums will apply to kidney, pancreas/kidney, bone marrow, tissue or cornea transplants.

Additional organ/tissue transplants will be considered for coverage provided that the transplant is Medically Necessary, not Experimental and is considered accepted medical practice for your Condition.

Organ/Tissue Transplant Pre-Certification - In order to receive full benefits for an organ/tissue transplant, the proposed course of treatment must be pre-certified and approved by Medical Mutual. In the event you do not obtain precertification, and your organ transplant is determined to not be Medically Necessary or is determined to be Experimental/Investigational, you may be responsible for all Billed Charges for that organ transplant.

After your Physician has examined you, he must provide Medical Mutual with:

- the proposed course of treatment for the transplant;
- the name and location of the proposed Transplant Center; and
- copies of your medical records, including diagnostic reports for Medical Mutual to determine the suitability and Medical Necessity of the transplant services. This determination will be made in accordance with uniform medical criteria that has been specifically tailored to each organ/tissue. You may also be required to undergo an examination by a Physician chosen by Medical Mutual. You and your Physician will then be notified of Medical Mutual's decision.

Obtaining Donor Organs or Donor Tissue - The following services will be Covered Services when they are necessary in order to acquire a legally obtained human organ/tissue:

- evaluation of the organ/tissue;
- removal of the organ/tissue from the donor; and
- transportation of the organ/tissue to the Transplant Center.

Donor Benefits - Benefits necessary for obtaining an organ/tissue from a living donor or cadaver are provided. Donor benefits are provided and processed under the transplant recipient's coverage only and are subject to any applicable limitations and exclusions. Donor benefits include treatment of immediate post operative complications if Medically Necessary as determined by Medical Mutual. Such coverage is available only so long as the recipient's coverage is in effect.

Non-PPO Network Provider services must have prior approval.

The Plan does not provide organ/tissue transplant benefits for services, supplies or Charges:

- **which are not furnished through a course of treatment which has been approved by Medical Mutual;**
- **for other than a legally obtained human organ/tissue;**
- **for travel time and the travel-related expenses of a Provider;**
- **that are related to other than human organ/tissue.**

Outpatient Institutional Services

The Covered Services listed below are covered when services are performed in an Outpatient setting, except as specified.

Covered Institutional services include, but are not limited to:

- operating, delivery and treatment rooms and equipment;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. The Plan will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded. **Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered;**

- anesthesia, anesthesia supplies and services; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

Pre-Admission Testing - Outpatient tests and studies required before a scheduled Inpatient Hospital admission or Outpatient surgical service are covered.

Post-Discharge Testing - Outpatient tests and studies required as a follow-up to an Inpatient Hospital stay or an Outpatient surgical service are covered.

Outpatient Therapy Services

Therapy services are services and supplies used to promote recovery from a Condition. Therapy services must be ordered by a Physician or Other Professional Provider to be covered. Covered Services are limited to the therapy services listed below:

Cardiac Rehabilitation Services - Benefits are provided for cardiac rehabilitation services which are Medically Necessary as the result of a cardiac event. The therapy must be reasonably expected to result in a significant improvement in the level of cardiac functioning.

Chemotherapy - The treatment of malignant disease by chemical or biological antineoplastic agents.

Chiropractic Visits - The treatment given by a chiropractor to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. These Covered Services include, but are not limited to, Office Visits, physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices. **Braces and molds are not covered under this benefit**.

Dialysis Treatments - The treatment of an acute or chronic kidney ailment by dialysis methods, including chronic ambulatory peritoneal dialysis, which may include the supportive use of an artificial kidney machine.

Hyperbaric Therapy - The provision of pressurized oxygen for treatment purposes. These services must be provided by a Hospital.

Occupational Therapy - Occupational therapy services are covered if it is expected that the therapy will:

- result in a significant improvement in the level of functioning; and
- that improvement will occur within 60 days of the first treatment.

All occupational therapy services must be performed by a certified, licensed occupational therapist.

Occupational therapy services are not Covered Services when a patient suffers a temporary loss or reduction of function which is expected to improve on its own with increased normal activities.

Physical Therapy - The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. These Covered Services include physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices. **Braces and molds are not covered under this benefit.**

All physical therapy services must be performed by an appropriately licensed Provider.

No benefits are provided once a patient can no longer significantly improve from treatment for the current Condition unless it is determined to be Medically Necessary by Medical Mutual.

Radiation Therapy - The treatment of disease by X-ray, radium or radioactive isotopes.

Respiratory/Pulmonary Therapy - Treatment by the introduction of dry or moist gases into the lungs.

Speech Therapy - In order to be considered a Covered Service, this therapy must be performed by a certified, licensed therapist and be Medically Necessary due to a medical Condition such as:

- a congenital abnormality;
- a stroke;
- aphasia;
- dysphasia; or
- post-laryngectomy.

Physical Medicine and Rehabilitation Services

Coverage is provided for acute Inpatient care from a Provider for physical rehabilitation services received in a rehabilitation facility.

Private Duty Nursing Services

The services of a registered nurse, licensed vocational nurse or licensed practical nurse when ordered by a Physician are covered. These services include skilled nursing services received in a patient's home or on an Outpatient basis. Your Physician must certify all services initially and continue to certify that you are receiving Skilled Care and not Custodial Care as requested by Medical Mutual. All Covered Services will be provided according to your Physician's treatment plan and as authorized by Medical Mutual.

When private duty nursing services must be received in your home, nurse's notes must be sent in with your claim.

Private duty nursing services do not include care which is primarily nonmedical or custodial in nature such as bathing, exercising or feeding. Also, the Plan does not cover services provided by a nurse who usually lives in your home or is a member of your Immediate Family. Non-PPO Network Provider services must have prior approval.

All private duty nursing services must be certified by your Physician initially and every two weeks thereafter, or more frequently if required by Medical Mutual, for Medical Necessity. **Inpatient private duty nursing services are not covered.**

Routine and Wellness Services

Child Health Supervision Services and Well Child Care - Regardless of Medical Necessity, coverage for child health supervision services will be provided for Eligible Dependent children.

Child health supervision services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination (examinations covered to age 21) and developmental assessment. Vision tests and the developmental assessment must be included as part of the physical examination in order to be provided as part of this benefit. This review also includes anticipatory guidance, laboratory tests (covered for Eligible Dependent children to age 21) and appropriate immunizations (covered for Eligible Dependent children to age 21). Routine hearing examinations are also covered for Eligible Dependent children to age 21.

Immunizations - The following immunizations are covered:

- hemophilis influenza B (HEPB-HIB)
- hepatitis A,B, A & B and hepatitis b
- human papillomavirus vaccine (HPV)
- influenza
- measles
- measles and rubella
- mumps
- MMR (measles, mumps and rubella)
- meningococcal vaccine
- pneumonia
- pneumococcal conjugate vaccine
- polio
- rotavirus (Rota) (under age 21)
- rubella
- tetanus toxoid
- varicella (VSV)

- zoster (age 19 and older)

The administration of routine therapeutic injections, including the administration of Depo Provera is also covered.

Routine Gynecological Services - The following services are covered:

- PAP tests; and
- examinations in conjunction with PAP tests.

Obesity Services - The following are Covered Services for a Medically Necessary Condition or obesity:

- office visits;
- diabetic management programs, including dietician visits;
- nutritional guidance;
- nutritional counseling;
- medical nutrition therapy;
- weight management classes;
- nutrition classes; and
- weight loss surgery (must be approved)

Routine Physical Examinations received from a PPO Network Provider - Routine physical examinations are covered for Covered Persons 21 years of age and older.

Routine Physical Examinations received from a Non-PPO Network Provider - Routine physical examinations are covered for Covered Persons 40 years of age and older.

Routine Testing - The following services are covered:

- Blood glucose tests
- Cholesterol tests
- Complete Blood Count (CBC) (covered for ages 21 and older)
- Comprehensive Metabolic Panel (covered for ages 21 and older)
- Endoscopic services, meaning: Anoscopy, colonoscopy, proctosigmoidoscopy and sigmoidoscopy, if a diagnosis of a medical Condition is made during a routine screening, (e.g., removal of a polyp), the screening is no longer considered routine and may be payable as a Medically Necessary, diagnostic procedure under the Surgical Services benefits. A Deductible, Copayment and/or Coinsurance may apply.
- Fecal occult blood tests
- Hematocrit tests
- Hemoglobin tests
- Human Papilloma Virus (HPV) tests
- Mammogram services for both men and women
- Prostate Specific Antigen (PSA) tests
- Routine x-ray, laboratory and medical testing services
- Urinalysis (UA) (covered for ages 21 and older)
- Venipuncture

Additional Preventive Services

If not shown elsewhere in the Benefit Book, the following services will also be covered without regard to any Deductible, Copayment or Coinsurance requirement that would otherwise apply:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration;

- With respect to Covered Persons who are women, such additional preventive care and screenings not described in the first bullet point above in this section, but as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Please refer to the phone number on the back of your identification card if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/center/regulations/prevention.html.

Skilled Nursing Facility Services

The benefits available to an Inpatient of a Hospital listed under the Inpatient Hospital Services section are also available to an Inpatient of a Skilled Nursing Facility. These services must be Skilled Care, and your Physician must certify all services initially and continue to certify that you are receiving Skilled Care and not Custodial Care as requested by Medical Mutual. All Covered Services will be provided according to your Physician's treatment plan and as authorized by Medical Mutual. Non-PPO Network Provider services must have prior approval.

No benefits are provided:

- **once a patient can no longer significantly improve from treatment for the current Condition unless it is determined to be Medically Necessary by Medical Mutual;**
- **for Custodial Care, rest care or care which is only for someone's convenience; and**
- **for the treatment of Mental Illness, Drug Abuse or Alcoholism.**

Surgical Services

Surgery - Coverage is provided for Surgery. In addition, coverage is provided for the following specified services:

- sterilization, regardless of Medical Necessity;
- therapeutic abortions;
- removal of bony impacted teeth
- maxillary or mandibular frenectomy;
- diagnostic endoscopic procedures, such as colonoscopy and sigmoidoscopy;
- reconstructive Surgery following a mastectomy, including coverage for reconstructive Surgery performed on a non-diseased breast to establish symmetry as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas;
- Surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes as determined by Medical Mutual, subject to any appeal process. **Surgery to correct a deformity or birth defect for psychological reasons, where there is no functional impairment, is not covered.**

Diagnostic Surgical Procedures - Coverage is provided for surgical procedures to diagnose your Condition while you are in the Hospital. The diagnostic surgical procedure and Medical Care visits except for the day the surgical procedure was performed are covered.

Oral Surgery - Coverage is provided for the following services **when these services are not covered by any dental plan:**

- oral surgery, including: osseous surgery;
- extraction of erupted tooth or exposed tooth by elevation and/or forceps removal;
- surgical removal of erupted tooth; and
- removal of soft tissue impacted tooth.

Multiple Surgical Procedures - When two or more Surgeries are performed through the same body opening during one operation, you are covered only for the most complex procedure. However, if each Surgery is mutually exclusive of the other, you will be covered for each Surgery. **Incidental Surgery is not covered.**

When two or more surgical procedures are performed through different body openings during one operation, you are covered for the most complex procedure, and the Traditional Amount for the secondary procedures will be half of the Traditional Amount for a single procedure.

If two or more foot Surgeries (podiatric surgical procedures) are performed, you are covered for the most complex procedure, and the Traditional Amount will be half of the Traditional Amount for the next two most complex procedures. For all other procedures, the Traditional Amount will be one-fourth of the full Traditional Amount.

Assistant at Surgery - Another Physician's help to your surgeon in performing covered Surgery when a Hospital staff member, intern or resident is not available is a Covered Service.

Anesthesia - Your coverage includes the administration of anesthesia, performed in connection with a Covered Service, by a Physician, Other Professional Provider or certified registered nurse anesthetist who is not the surgeon or the assistant at Surgery or by the surgeon in connection with covered oral surgical procedures. This benefit includes care before and after the administration. The services of a stand-by anesthesiologist are only covered during coronary angioplasty Surgery.

Second Surgical Opinion - A second surgeon's opinion and related diagnostic services to help determine the need for elective covered Surgery recommended by a surgeon are covered but are not required.

The second surgical opinion must be provided by a surgeon other than the first surgeon who recommended the Surgery. This benefit is not covered while you are an Inpatient of a Hospital.

If the first and second surgical opinions conflict, a third opinion is covered. The Surgery is a Covered Service even if the Physicians' opinions conflict.

Temporomandibular Joint Syndrome Services

Temporomandibular Joint Syndrome (TMJ) is a Condition which causes pain or dysfunction in the temporomandibular joint and/or the temporal region. This syndrome may include limited motion of the jaw caused by improper occlusal alignment. Occlusal refers to the fit of the teeth as the two jaws meet.

The Covered Services listed below are covered when Medically Necessary for the diagnosis and treatment of TMJ:

- diagnostic services;
- physical therapy;
- office visits; and
- orthotic appliances.

Weight Loss Surgery Services

Weight loss Surgery is eligible for coverage when the Covered Person's attending Physician and Medical Mutual both determine that such Surgery is Medically Necessary.

Please contact Medical Mutual's Care Management department for more information.

EXCLUSIONS

In addition to the exclusions and limitations explained in the Health Care Benefits section, coverage is not provided for the following services and supplies:

1. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
2. Services not performed within the scope of the provider's license.
3. Services received from a member of your immediate family.
4. Services that would be provided free of charge in the absence of insurance.
5. Charges which exceed the Allowed Amount.
6. Services that are not medically necessary or are not classified as preventive services.
7. Services received before the effective date of your contract or services not specifically covered by your contract.
8. Incurred after you stop being a Covered Person except as specified in the Benefits After Termination of Coverage section.
9. A Condition occurring in the course of employment or for occupational injuries sustained by sole proprietors, if whole or partial benefits or compensation could be available under the laws of any governmental unit. This applies whether or not you claim such compensation or recover losses from a third party.
10. Which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
11. Received in a military facility for a military service related Condition.
12. Custodial care, care in a sanitarium, rest home, nursing home, rehabilitation facility, health resort, health spa, institution for chronic care, personal care, residential or domiciliary care, home for the aged, camp or school.
13. Services rendered or supplies furnished principally for custodial care, which includes, but is not limited to, non-medical day-to-day patient care such as assisting the patient getting dressed and using bathroom facilities; services rendered for care of senile deterioration, mental deficiency or retardation.
14. Convalescence care.
15. Residential care rendered by a Residential Treatment Facility.
16. Devices simulating natural body contours unless prescribed in connection with a mastectomy.
17. Expenses of injury or illness paid for or furnished by an employer, whether under workers' compensation or otherwise, and services provided and paid by any governmental program or hospital.
18. Illness or injury related to declared or undeclared war or by participation in civil disturbance.
19. Clinic charges that are services billed by a resident, intern or other employee of a hospital or skilled nursing facility.
20. Services for emergency first aid that are rendered in the office, place of business or other facility maintained by the employer.
21. Services for which no claim was submitted within 15 months of the date of service.
22. Charges for mileage costs or for completion of claim forms or for preparation of medical reports.
23. Expenses that are covered under any other State of Ohio insurance program, such as United Behavioral Health.
24. Chest X-rays and preventive care not necessary to the treatment of an illness, injury or disease, unless specifically allowed.
25. Local anesthesia when billed separately, and hypnotism used for anesthetic purposes.
26. Elective cosmetic surgery performed only for the purpose of changing or improving appearance.
27. Surgery to correct a deformity or birth defect for psychological reasons where there is no functional impairment.
28. The removal of tattoos.
29. Personal comfort services such as telephones, radio, television, barber and beauty services, or in connection with air conditioners, air purification units, humidifiers, allergy-free pillows, blankets or mattress covers, electric heating units, swimming pools, orthopedic mattresses, vibratory equipment, elevator or stair lifts, blood pressure instruments,

stethoscopes, clinical thermometers, scales, elastic bandages, compression stockings, or wigs, unless otherwise provided by a specific benefit.

30. Ordinary bandages and dressings.
31. Vitamins, herbal remedies, dietary or food supplements or non-prescription drugs.
32. Prescription and over the counter drugs, including weight loss drugs.
33. Growth hormones.
34. Routine foot care, except for diabetics.
35. Orthotics, except for diabetics.
36. Treatments, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss, except as specified.
37. Weight loss Surgery and any related complications, unless such Surgery is determined by Medical Mutual to be Medically Necessary. In order for any benefits to be considered, approval from Medical Mutual must be obtained in advance of receiving treatment.
38. Needles and syringes, including insulin pens and insulin pen needles, lancets and lancing devices, alcohol prep pads, blood glucose/urine test and reagent strips or tablets, non-prescription glucose tabs, blood glucose meters, calibrator solutions and chips, glucagon emergency kits, testing solutions, and replacement batteries (alkaline 1.5v and 4.5v) for infusion pumps for diabetics only.
39. Contraceptives, except as specified under the "Contraceptive Services section".
40. In vitro fertilization and embryo transplantation, artificial insemination, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), assisted reproductive technology (ART) and any costs associated with the collection, preparation or storage of sperm for artificial insemination, including donor fees.
41. Reverse sterilization.
42. Pregnancy Termination. The Ohio Med plans do not provide benefits or services related to non-therapeutic abortions for any State of Ohio employee or dependent. "Non-therapeutic" is defined as an abortion that is performed or induced when the life of the mother would not be endangered if the fetus were carried to term, or when the pregnancy was not the result of rape or incest reported to a law enforcement agency.
43. The medical treatment of sexual problems not caused by a biological Condition.
44. Transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
45. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.
46. Marital counseling.
47. Dental care, except as noted elsewhere.
48. Oral implants considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic except when due to trauma, accident or as deemed Medically Necessary by Medical Mutual.
49. Eyeglasses or contact lenses, or related examinations, unless necessitated as a result of an injury, illness or disease.
50. Any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).
51. Treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis, unless specified.
52. Services rendered principally for care of mental illness (these services are covered by United Behavioral Health), except as specified in the "Mental Health Care Services" section.
53. Services rendered beyond the period of time generally considered necessary for diagnosis of mental retardation or mental deficiency.
54. Services rendered for a psychiatric condition usually considered to be irremediable, except for the purpose of diagnosis of the condition as being irremediable.
55. Services provided in connection with autism, pervasive developmental disorders or learning disabilities except for the purpose of diagnosis of the condition.
56. Examinations and procedures performed for screening or testing done without necessity, when not indicated by symptoms or performed for treatment, including pre-marital testing surveys, research, and any procedure performed in connection with a physical examination ordered or required by an employer as a condition of employment or the continuance of employment.

57. Any services rendered primarily for training or educational purposes, self-administered services and services directed toward self-enhancement, except as otherwise specified.
58. Treatment programs whose value is not proven or is under investigation, research-oriented treatment, developmental or perceptual therapy, primal therapy, biofeedback, marriage counseling, orthomolecular testing and therapy, cathectathon therapy, marathon therapy and collaborative therapy. A drug or treatment is considered experimental or investigational if it cannot be legally marketed in the U.S.; it is subject of phase I, II or III clinical trials or under study to determine dosage, toxicity, safety, efficacy or efficacy compared with standard means of treatment; or reliable evidence shows that the consensus of experts is that further studies are necessary to determine maximum dosage, toxicity, safety, efficacy or efficacy compared with standard means of treatment (except Cancer Clinical Trials.).
59. Acupuncture, hypnosis and massage therapy.
60. Immunizations that are required for purposes of travel or for other than those specified as covered in the Routine and Wellness Services section of the Benefit Book.
61. Water aerobics.
62. Telephone consultations, online consultations,missed appointments, completion of claim forms or copies of medical records.
63. Fraudulent or misrepresented claims.
64. Blood which is available without charge. For Outpatient blood storage services.
65. A particular health service in the event that a Non-PPO Network Provider waived Copayments, Non-PPO Network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period) no benefits are provided for the health service for which the Copayments, Non-PPO Network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period) are waived.
66. Any service for which a benefit is not specifically provided by the Ohio Med plan.

GENERAL PROVISIONS

How to Apply for Benefits

Notice of Claim; Claim Forms

A claim must be filed for you to receive benefits. Many Providers will submit a claim for you; if you submit it yourself, you should use a claim form. In most cases, you can obtain a claim form from your Group or Provider. If your Provider does not have a claim form, Medical Mutual will send you one. Call or notify Medical Mutual, in writing, within 20 days after receiving your first Covered Service, and Medical Mutual will send you a form or you may print a claim form by going to www.MedMutual.com under Members' section.

If you fail to receive a claim form within 15 days after you notify Medical Mutual, you may send Medical Mutual your bill or a written statement of the nature and extent of your loss; this must have all the information which Medical Mutual needs to process your claim.

Proof of Loss

Proof of Loss is a claim for payment of health care services which has been submitted to Medical Mutual for processing with sufficient documentation to determine whether Covered Services have been provided to you. Medical Mutual must receive a completed claim with the correct information. Medical Mutual may require Provider's notes or other medical records before Proof of Loss is considered sufficient to determine benefit coverage.

Medical Mutual is not legally obligated to reimburse for Covered Services on behalf of the Plan unless written or electronically submitted proof that Covered Services have been given to you is received. Proof must be given within 90 days of your receiving Covered Services or as soon as is reasonably possible. No proof can be submitted later than 15 months after services have been received.

How Claims are Paid

Medical Mutual, as the claims administrator, pays for benefits on behalf of the Plan for Covered Services through agreements with Contracting Institutional Providers and Participating Physicians and Other Professional Providers based on Negotiated Amounts. For Non-Contracting Institutional Providers, Medical Mutual pays for benefits based on the Non-Contracting Amount that is determined payable by Medical Mutual. For Non-Participating Physicians and Other Professional Providers, Medical Mutual pays for benefits based on Traditional Amounts.

For Emergency Services received from a Non-PPO Network Provider, Medical Mutual pays for benefits in an amount equal to the greatest of the following:

1. The Negotiated Amount. If more than one amount is negotiated with PPO Network Providers for the Emergency Service, the amount payable is the median of these amounts.
2. The Non-Contracting Amount.
3. The amount that would be paid under Medicare for the Emergency Service.

Any charges exceeding the Negotiated Amount, Traditional Amount, Non-Contracting Amount or the amount payable for Non-PPO Network Emergency Services described above will not apply toward the Deductible, Coinsurance Limit or plan maximum accumulation.

Benefit Period Deductible

Each Benefit Period, you must pay the dollar amount that may be specified in the Schedule of Benefits as the Deductible before the Plan will begin to provide benefits. This is the amount of expense that must be Incurred and paid by you for Covered Services before the Plan starts to provide benefits. If a benefit is subject to a Deductible, only expenses for Covered Services under that benefit will satisfy the Deductible. To satisfy your Deductible, the Plan records must show that you have Incurred claims totaling the specified dollar amount, so submit copies of all your bills for Covered Services. Your Deductible accumulations do not necessarily occur in the same order that you receive services, but in the order in

which Medical Mutual receives and processes your claims. Copayments will not apply to the Deductible. Deductibles do not apply to the Coinsurance Limit. Deductibles, Coinsurance and specified Copayments do however apply to your Out-of-Pocket Maximum.

The Schedule of Benefits may specify a single Deductible and a family Deductible. The single Deductible is the amount each Covered Person must pay, but the total amount the family must pay is limited to the family Deductible.

Coinsurance

After you meet any applicable Deductible, you may be responsible for Coinsurance amounts as specified in your Schedule of Benefits, subject to any limitations set forth in the Schedule of Benefits. The amount of Coinsurance you have to pay may vary depending upon the status of your Provider.

If a Coinsurance limit applies, the Schedule of Benefits may specify a single Coinsurance Limit, a family Coinsurance Limit, a single Non-PPO Network Coinsurance Limit and a family Non-PPO Network Coinsurance Limit. The single limit is the amount each Covered Person must pay, but the family limit is the total amount the family must pay based on the respective limits.

Copayments

For some Covered Services, you may be responsible for paying a Copayment at the time services are rendered. Covered Services that require Copayments may or may not be subject to Deductible and or Coinsurance requirements as specified in your Schedule of Benefits. These Copayments are your responsibility, and they are not reimbursed by the Plan. Please refer to your Schedule of Benefits for specific Copayment amounts that may apply.

Schedule of Benefits

The Deductibles, Coinsurance Limits and Non-PPO Network Coinsurance Limits that may apply will renew each Benefit Period. Some of the benefits offered in this Benefit Book have maximums. In addition, there may be a lifetime maximum for all Covered Services listed in this Benefit Book and Medical Mutual's Negotiated Amounts.

The Schedule of Benefits shows your financial responsibility for Covered Services. The Plan covers the remaining liability for Covered Charges after you have paid the amounts indicated in the Schedule of Benefits, subject to benefit maximums and Medical Mutual's Negotiated Amounts.

Your Financial Responsibilities

You are responsible for paying Non-Covered Charges, Billed Charges for all services and supplies after benefit maximums have been reached, and Excess Charges for services and supplies rendered by Non-Contracting and Non-Participating Providers. Your financial responsibilities include the Deductible amounts specified in the Schedule of Benefits. Copayments, Coinsurance and Non-PPO Network Coinsurance are also your responsibility. You are responsible for payment for services that are not Medically Necessary and for incidental charges.

For Covered Services rendered by Contracting Institutional Providers, Physicians and Other Professional Providers, Medical Mutual will calculate your Deductible, Coinsurance, Non-PPO Network Coinsurance and benefit maximum accumulations based on the Lesser Amount. Your financial responsibility to the Provider for Covered Services will also be based on the Lesser Amount. For Non-Participating Physicians and Other Professional Providers, you may be responsible for Excess Charges.

For Covered Services received from Contracting Institutional Providers and Participating Physicians and Other Professional Providers, the Provider has agreed not to bill for any amount of Covered Charges above the Negotiated Amount, except for services and supplies for which the Plan has no financial responsibility due to a benefit maximum.

For Covered Services rendered by Non-Contracting Institutional Providers, Medical Mutual will calculate your Deductible, Coinsurance and benefit maximum accumulations based on the Non-Contracting Amount as determined by Medical Mutual. You may be responsible for Excess Charges.

For Covered Services received from Non-PPO Network Providers, you may be responsible for the Non-PPO Network Coinsurance. The Non-PPO Network Coinsurance continues until your Non-PPO Network Coinsurance Limit is reached.

All limits and Coinsurance applied to a specific diagnosed Condition include all services related to that Condition. If a specific service has a maximum, that service will also be accumulated to all other applicable maximums. Example: If your coverage includes both a TMJ benefit limit of $1,000 per Benefit Period and a physical therapy visit limit of 10 visits per Benefit Period. If you receive physical therapy for a TMJ diagnosis, the value of those services will be applied to both the TMJ maximum and the physical therapy visit limit.

Deductibles, Copayments, Coinsurance and amounts paid by other parties do not accumulate towards benefit maximums.

Provider Status and Direction of Payment

Medical Mutual has agreed to make payment directly to Contracting Institutional Providers and Participating Physicians and Other Professional Providers for Covered Services.

Some of Medical Mutual's contracts with Providers, including Institutional Providers, allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual and/or the Group, and Medical Mutual and/or the Group will retain any payments resulting therefrom; however, the Deductibles, Copayments, Coinsurance, Non-PPO Network Coinsurance and benefit maximums, if applicable, will be calculated as described in this Benefit Book.

The choice of a Provider is yours. After a Provider performs a Covered Service, Medical Mutual will not honor your request to withhold claim payment. Medical Mutual and the Group do not furnish Covered Services but only pay for Covered Services you receive from Providers. Neither Medical Mutual nor the Group is liable for any act or omission of any Provider. Neither Medical Mutual nor the Group have any responsibility for a Provider's failure or refusal to give Covered Services to you.

Medical Mutual has and retains the sole right to choose which Providers it will contract with, and on what terms, and to amend and terminate those contracts. Medical Mutual has and retains the sole right to designate Providers as Contracting and/or PPO Network.

You authorize Medical Mutual to make payments directly to Providers who have performed Covered Services for you. Medical Mutual also reserves the right to make payment directly to you. When this occurs, you must pay the Provider and neither Medical Mutual nor the Group are legally obligated to pay any additional amounts. You cannot assign your right to receive payment to anyone else, nor can you authorize someone else to receive your payments for you, including your provider.

If Medical Mutual has incorrectly paid for services or it is later discovered that payment was made for services which are not considered Covered Services, then Medical Mutual has the right to recover payment on behalf of the Group, and you must repay this amount when requested.

Any reference to Providers as PPO Network, Non-PPO Network, Contracting, Non-Contracting, Participating or Non-Participating is not a statement about their abilities.

Pre-Authorization of Non-PPO Network Benefits

In some cases, Medical Mutual may determine that certain Covered Services can only be provided by a Non-PPO Network Provider. If Covered Services provided by a Non-PPO Network Provider are pre-authorized by Medical Mutual, benefits will be provided as if the Covered Services were provided by a PPO Network Provider.

To pre-authorize treatment by a Non-PPO Network Provider, your Physician must provide Medical Mutual with:

- the proposed treatment plan for the Covered Services;
- the name and location of the proposed Non-PPO Network Provider;
- copies of your medical records, including diagnostic reports; and
- an explanation of why the Covered Services cannot be provided by a PPO Network Provider.

Medical Mutual will determine whether the Covered Services can be provided by a PPO Network Provider and that determination will be final and conclusive. Medical Mutual may elect to have you examined by a Physician of its choice and will pay for any required physical examinations. You and your Physician will be notified if Covered Services provided by a Non-PPO Network Provider will be covered as if they had been provided by a PPO Network Provider.

If you do not receive written pre-authorization for Covered Services, benefits will be provided as described in the Schedule of Benefits for Covered Services received from a Non-PPO Network Provider.

Explanation of Benefits

After Medical Mutual processes your claim, an Explanation of Benefits (EOB) is provided to you electronically or by mail. It lists Covered Services and non-covered services along with explanations for why services are not covered. It contains important amounts, appeal information and a telephone number if you have any questions.

Time of Payment of Claims

Benefits will be provided under this Benefit Book within 30 days after receipt of a completed claim. To have a payment or denial related to a claim reviewed, you must send a written request or call Customer Service at Medical Mutual within 180 days of the claim determination.

Benefit Determination for Claims

Urgent Care Claims

An Urgent Care Claim is a claim for Medical Care or treatment where applying the timeframes for non-urgent care could (a) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (b) 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.

Determination of ***urgent*** can be made by (a) an individual acting on behalf of the plan and applying the judgment of a prudent lay person who possesses an average knowledge of medicine or (b) any Physician with a knowledge of the claimant's medical Condition can determine that a claim involves urgent care.

If you file an Urgent Care Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination, whether adverse or not, as soon as possible but not later than 72 hours after Medical Mutual's receipt of the claim.

If you do not follow Medical Mutual's procedures or we do not receive all of the information necessary to make a benefit determination, Medical Mutual will notify you within 24 hours of receipt of the Urgent Care Claim and explain the applicable procedural deficiencies, or the specific deficiencies related to information necessary to make a benefit determination. You will have 48 hours to correct the procedural deficiencies and/or provide the requested information. Once Medical Mutual receives the requested information, we will notify you of the benefit determination as soon as possible, taking into account all medical exigencies, but not later than 48 hours after receipt of the information.

Medical Mutual may notify you of its benefit determination decision orally and follow with written or electronic notification not later than three (3) days after the oral notification.

Concurrent Care Claims

A Concurrent Care Claim is any claim for ongoing treatment to be provided over a period of time or for a number of treatments, subject to a plan's approval. The decision is adverse if the Plan decides to reduce or terminate benefits for the ongoing treatment (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination).

A request for an extension to an ongoing course of treatment must be filed in accordance with Medical Mutual's claim procedures and must be made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Medical Mutual will notify you of any benefit determination concerning the request to extend the course of treatment within 24 hours after its receipt of the claim.

If Medical Mutual reduces or terminates a course of treatment before the end of the course previously approved, then the reduction or termination is considered an adverse benefit determination. Medical Mutual will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

Pre-Service Claims

A Pre-Service Claim is a claim for a benefit which requires some form of preapproval or precertification by Medical Mutual as a condition for payment of a benefit (either in whole or in part).

If you file a Pre-Service Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination within 15 days after receipt of the claim. Medical Mutual may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of Medical Mutual. Medical Mutual will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, Medical Mutual will notify you, in writing, within the initial 15 day response period and will specifically describe the missing

information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Post-Service Claims

A Post-Service Claim is any claim that is not a Pre-Service Claim or an Urgent Care Claim.

If you file a Post-Service Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination within 30 days after receipt of the claim. Medical Mutual may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of Medical Mutual. Medical Mutual will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, Medical Mutual will notify you, in writing, within the initial 30 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Benefit Determination Notices

You will receive notice of a benefit determination, orally as allowed, or in writing in a culturally and linguistically appropriate manner. All notices of a denial of benefit will include the following:

- Information sufficient to identify the claim or health care service involved, including the health care provider, the date of service, and claim amount, if applicable;
- the specific reason(s) for the denial;
- reference to the specific plan provision(s) on which the denial is based;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of Medical Mutual's appeal procedures and applicable timeframes, including the expedited appeal process, if applicable;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of your right to bring a civil action under federal law following the denial of a claim after review on appeal, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA);
- disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the claim was denied based on Medical Necessity, Experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

Filing a Complaint

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, the Certificate Holder should have the following information available:

- name of patient
- identification number
- claim number(s) (if applicable)
- date(s) of service

If your complaint is regarding a claim, a Medical Mutual Customer Service representative will review the claim for correctness in processing. If the claim was processed according to terms of the Group Contract, the Customer Service representative will telephone the Certificate Holder with the response. If attempts to telephone the Certificate Holder are

unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the Certificate Holder will receive a check, Explanation of Benefits or letter explaining the revised decision.

Quality of Care issues are addressed by our Quality Improvement Department or committee.

If you are not satisfied with the results, you may continue to pursue the matter through the appeal process.

Filing an Appeal

Filing an Appeal

If you are not satisfied with an adverse benefit determination, you may file an appeal.

To submit an appeal electronically, go to Medical Mutual's Web site, www.MedMutual.com, under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card. You may also write a letter with the following information: Certificate Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, documents, dental X-rays or photographs you would like considered in the appeal. Send or fax the letter and records to:

Medical Mutual
Member Appeals Unit
MZ: 01-4B-4809
P.O. Box 94580
Cleveland, Ohio 44101-4580
FAX: (216) 687-7990

The request for review must come directly from the patient unless he/she is a minor or has appointed an authorized representative. You can choose another person to represent you during the appeal process, as long as Medical Mutual has a signed and dated statement from you authorizing the person to act on your behalf.

Mandatory Internal Appeal Level

The Plan offers all members a mandatory internal appeal level. You must complete this mandatory internal appeal level before any additional action is taken, except when exhaustion is unnecessary as described in the following sections.

Mandatory internal appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of benefits. All requests for appeal may be made by submitting an electronic form, by calling Customer Service or in writing as described above in the Filing an Appeal section.

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law. The internal appeal process is a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The review of an appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations that involve, in whole or in part, issues of Medical Necessity, whether services are Experimental and Investigational, or any other medical judgment, are based on the evaluations and opinions of health care professionals who have the appropriate training and experience in the field of medicine involved in the medical condition and the treatment or service for which coverage is requested. The health care professionals who review the appeal will not have made any prior evaluations about your claim and will not be a subordinate of the professional who made the initial evaluation of your claim. These health care professionals act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits. Upon specific written request from you, Medical Mutual will provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

You may submit written comments, documents, records, testimony and other information relating to the claim that is the basis for the appeal. These documents should be submitted by you at the time you send in your request for an appeal. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that is the subject of your appeal.

If, during the appeal, Medical Mutual considers, relies upon or generates any new or additional evidence, you will be provided free of charge with copies of that evidence before a notice of denial is issued. You will have an opportunity to respond before our time frame for issuing a notice of denial expires. Additionally, if Medical Mutual decides to issue a final denial based on a new or additional rationale, you will be provided that rationale free of charge before the final notice of denial is issued. You will have an opportunity to respond before our timeframe for issuing a notice of denial expires.

You will receive continued coverage pending the outcome of the appeals process. This means that the Plan may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review.

The appeal procedures are as follows:

Urgent Care Appeal

- You, your authorized representative or your Provider may request an appeal for urgent care. The appeal does not need to be submitted in writing. You, your authorized representative, or your Physician should call the Care Management telephone number on your identification card as soon as possible. Urgent care claim appeals are typically those claims for Medical Care or treatment where withholding immediate treatment (1) could seriously jeopardize the life or health of a patient, or could affect the ability of the patient to regain maximum functions, or (2) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The appeal must be decided with 72 hours of the request. The expedited review process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

Pre-Service Claim Appeal

- You or your authorized representative may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the plan Certificate. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of denial.

Post Service Claim Appeal

- You or your authorized representative may request a post-service claim appeal. Post-service claim appeals are those requested for payment or reimbursement of the cost for Medical Care that has already been provided. As with pre-service claims, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of the denial.

Appeal Denial Notices

All notices of a denial of an appeal will be culturally and linguistically appropriate and will include the following:

- Information sufficient to identify the claim or health care service involved, including the health care provider, the date of service, and claim amount, if applicable;
- the specific reason(s) for the denial;
- reference to the specific plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- if the claim was denied based on a Medical Necessity or Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request;
- a discussion of the decision;
- a description of applicable appeal procedures;
- disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance; and

- notice of your right to bring civil action under federal law following the denial of a claim upon review, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

If your claim is denied at the mandatory internal appeal, you may be eligible for either the External Review Process by an Independent Review Organization or the External Review Process by the Ohio Department of Insurance for contractual issues. Prior to requesting an External Review (but not after requesting an External Review), you may request an additional Voluntary Internal Level Appeal. Alternatively, you may request an External Review directly after receiving a denial at the mandatory internal appeal level. The Voluntary Internal Level Appeal and External Review Processes are described below.

Voluntary Internal Level Appeal

Unless your Group requires you to use an alternative dispute resolution procedure, if your mandatory internal appeal is denied, then you have the option of a voluntary internal level appeal by Medical Mutual. All requests for appeal may be made by calling Customer Service or writing to the Member Appeals Department. You should submit additional written comments, documents, records, dental X-rays, photographs and other information that were not submitted for the mandatory internal appeal.

The voluntary internal level of appeal may be requested at the conclusion of the mandatory internal appeal level. The request for the voluntary internal level of appeal must be received by Medical Mutual within 60 days from the receipt of the mandatory internal appeal decision. Medical Mutual will complete its review of the voluntary internal level appeal within 30 days from receipt of the request.

The voluntary internal level appeal provides a full and fair review of the claim. There will be a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the mandatory internal appeal level. All determinations that involve, in whole or in part, issues of Medical Necessity, whether services are Experimental and Investigational, or any other medical judgment, are based on the evaluations and opinions of health care professionals who have the appropriate training and experience in the field of medicine involved in the medical condition and the treatment or service for which coverage is requested. The health care professionals who review the appeal will not have made any prior evaluations about your claim and will not be a subordinate of the professional who made any prior evaluation of your claim. These health care professionals act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits. Upon specific written request from you, Medical Mutual will provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

You may submit written comments, documents, records and other information relating to the claim that is the basis for the appeal. These documents should be submitted by you at the time you send in your request for a voluntary internal level of appeal. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that is the subject of your appeal.

External Review Process by an Independent Review Organization

In accordance with state law, Medical Mutual has established an external review process to examine coverage decisions under certain circumstances. You may be eligible to have a decision reviewed by the external review process if you meet the following criteria:

1. the adverse benefit determination involved a medical judgment or the determination was based on any medical information (such as adverse benefit determinations involving an issue of Medical Necessity, whether the treatment or services are Experimental and Investigational, appropriateness, health care setting, or level of care or effectiveness); and
2. you have exhausted the mandatory internal appeal process described above.

The internal appeal process will be considered exhausted if you have requested an internal appeal and have not received a written decision from Medical Mutual within the timeframes required by 23 C.F.R. 2560.503-1 (which may vary or not apply depending on the type of plan you have and the type of coverage at issue) or Medical Mutual fails to adhere to all requirements of the internal appeals process. Notwithstanding the preceding sentence, you may not make a request for an external review of an adverse benefit determination involving a retrospective review determination made pursuant to a utilization review until you have exhausted Medical Mutual's internal appeals process. Additionally, the internal appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the covered person so long as Medical Mutual demonstrates that the violation was for good cause

or due to matters beyond the control of Medical Mutual and that the violation occurred in the context of an ongoing, good faith exchange of information between Medical Mutual and you, and is not reflective of a pattern or practice of noncompliance, except that:

1. If Medical Mutual denies a request for external review, you may request written explanation from Medical Mutual, and Medical Mutual will provide the explanation within ten days, including a specific description of the Medical Mutual's bases for asserting that the delay should not cause the internal appeals process to be considered exhausted;
2. You may request review by the Ohio Department of Insurance of Medical Mutual's explanation and if the Ohio Department of Insurance affirms Medical Mutual's explanation, you may, within ten days of the Ohio Department of Insurance's notice of decision, resubmit and pursue the internal appeal process. Time periods for refiling the internal appeal shall begin to run upon receipt of such notice to you.

You may make a request for an external review before you exhaust Medical Mutual's internal appeals procedures if Medical Mutual agrees to waive the exhaustion requirement.

You are NOT entitled to external review if:

1. The Ohio Department of Insurance determined that the health care service is not a Covered Service under your Certificate; or
2. You have already had an external review for the same adverse benefit determination and no new pertinent medical or scientific evidence has been submitted to Medical Mutual.

An external review will be conducted by an independent review organization accredited and assigned on a random basis by the Ohio Department of Insurance. You will not be required to pay for any part of the cost of the external review. The Plan is required by law to provide to the independent review organization conducting the review a copy of the documents and information considered in making the adverse benefit determination.

A request for an external review may be made by you or your authorized representative. If you do not request a voluntary internal level appeal, the request for external review must be made within 180 days from your receipt of the notice of denial after the mandatory internal appeal level. If you do request a voluntary internal level of appeal, the request for external review must be made within 180 days from your receipt of the notice of denial after the voluntary internal appeal level.

When you file a request for an external review, you will be required to authorize the release of your medical records as necessary to conduct the external review.

The types of external review by an independent review organization are standard external review, expedited external review, and external review for experimental or investigational treatment.

Standard External Review for Non-Expedited Appeals

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to Medical Mutual's Member Appeals Unit at the address listed previously.

Upon receipt of a request for an external review, Medical Mutual will review the request for completeness and eligibility. If the request is complete and eligible, Medical Mutual will initiate an external review. Medical Mutual will notify you in writing that the request is complete and include the following information:

1. name and contact information for the independent review organization assigned to the review
2. a statement that you may, within 10 business days after the date of receipt of the notice, submit, in writing, additional information for the independent review organization to review. The independent review organization is not required to, but may, accept and consider additional information submitted after the end of the 10 business day period.

If the request for review is not complete, Medical Mutual will inform you in writing, including what information is needed to make the request complete. If Medical Mutual denies a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, Medical Mutual will notify you in writing of the reason for the denial and that the denial may be appealed to the Ohio Department of Insurance.

If you submit information to the independent review organization to consider, the independent review organization will forward a copy of the information to Medical Mutual. Upon receipt of the information, the Plan may reconsider its adverse benefit determination and provide coverage for the health care service in question. Reconsideration by the Plan will not delay or terminate an external review. If the Plan reverses an adverse benefit determination, the Plan will notify you in writing and the independent review organization will terminate the external review.

The independent review organization will issue a written decision within 30 days of receipt of a request for review. This written decision will include a general description of the reason for the request for review, the date the independent review organization was assigned to conduct the review, the dates over which the external review was conducted, the date on which the independent review organization's decision was made, the rationale for its decision, and references to the evidence or documentation, including any evidence-based standards used, that were considered in reaching its decision. Upon receipt of a notice to reverse the adverse benefit determination, the Plan will provide coverage for the health care service in question.

Expedited External Review

A request for an external review for Urgent or Expedited claims may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation must be submitted to Medical Mutual no later than five days after the initial oral or electronic request is submitted. A request for an expedited review should be made by contacting the Care Management Department at the number on the back of your identification card.

A request for an expedited review may be made after an internal appeal denial is issued if either of the following apply:

1. Your treating physician certifies that the adverse benefit determination 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 for a standard external review; or
2. the adverse benefit determination 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.

A request for an expedited review may be made after an initial denial (before the internal appeal process is exhausted) if both of the following apply:

1. your treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize your life or health if treated after the timeframe of an expedited internal appeal; and
2. you have filed a request for an expedited internal appeal.

An expedited external review may not be provided for retrospective adverse benefit determinations.

Upon receipt of a request for an external review, Medical Mutual will review the request for completeness and eligibility and notify you of its determination. If the request is complete and eligible, Medical Mutual will initiate an external review.

The independent review organization will issue a decision within 72 hours after being assigned an expedited review request. If notice of this decision is not made in writing, the independent review organization will provide written confirmation within 48 hours. This written confirmation will include a general description of the reason for the request for review, the date the independent review organization was assigned to conduct the review, the dates over which the external review was conducted, the date on which the independent review organization's decision was made, the rationale for its decision, and references to the evidence or documentation, including any evidence-based standards used, that were considered in reaching its decision. Upon receipt of a notice to reverse the adverse benefit determination, the Plan will provide coverage for the health care service in question.

External Review Process for Experimental or Investigational Treatment

You are eligible to have an external review if you meet all of the following criteria:

1. You received an internal appeal denial based on a conclusion that a requested health care service is experimental or investigational, except when the requested health care service is explicitly listed as an excluded benefit under your plan; and
2. your treating Physician certifies that one of the following situations is applicable:
   a. standard health care services have not been effective in improving your Condition;
   b. standard health care services are not medically appropriate for you;
   c. no standard health care service, covered by the Plan, is more beneficial than the requested health care service

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You may request an expedited external review if you meet the criteria above and your treating physician certifies that the requested health care service in question would be significantly less effective if not promptly initiated.

You must request the review in writing unless your treating Physician certifies that the health care service would be significantly less effective if not promptly initiated, in which case you may make the request orally or by electronic means. You will not be required to pay for any part of the cost of the external review.

Upon receipt of a request for an external review, Medical Mutual will review the request for completeness and eligibility. If the request is complete and eligible, Medical Mutual will initiate an external review. Medical Mutual will notify you in writing that the request is complete and include the following information:

1. name and contact information for the independent review organization assigned to the review
2. except for an expedited request, a statement that you may, within 10 business days after the date of receipt of the notice, submit, in writing, additional information for the independent review organization to review. The independent review organization is not required to, but may, accept and consider additional information submitted after the end of the 10 business day period.

If the request for review is not complete, Medical Mutual will inform you in writing, including what information is needed to make the request complete. If Medical Mutual denies a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, Medical Mutual will notify you in writing of the reason for the denial and that the denial may be appealed to the Ohio Department of Insurance.

If you submit information to the independent review organization to consider, the independent review organization will forward a copy of the information to Medical Mutual. Upon receipt of the information, the Plan may reconsider its adverse benefit determination and provide coverage for the health care service in question. Reconsideration by the Plan will not delay or terminate an external review. If the Plan reverses an adverse benefit determination, the Plan will notify you in writing and the independent review organization will terminate the external review.

The independent review organization will issue a written decision within 30 days of receipt of a request for review, except if the request is for expedited review, a written decision will be issued within 72 hours of receipt of an expedited request. This written decision will include a general description of the reason for the request for review, written opinions of the clinical reviewers involved in the decision, the date the independent review organization was assigned to conduct the review, the dates over which the external review was conducted, the date on which the independent review organization's decision was made, and the principal reason and rationale for the independent review organization's decision. Upon receipt of a notice to reverse the adverse benefit determination, the Plan will provide coverage for the health care service in question.

External Review by the Ohio Department of Insurance for Adverse Benefit Determinations Based on Contractual Issues Not Involving Medical Judgment or any Medical Information

If Medical Mutual issued an adverse benefit determination based on a contractual issue that did not involve a medical judgment or any medical information, you have the right to request a review by the Ohio Department of Insurance.

A request for an external review by the Ohio Department of Insurance must be in writing and should be addressed to Medical Mutual's Member Appeals Unit at the address listed above. It can be made by you or your authorized representative. If you do not request a voluntary internal level appeal, the request for external review must be made within 180 days from your receipt of the notice of denial after the mandatory internal appeal level. If you do request a voluntary internal level of appeal, the request for external review must be made within 180 days from your receipt of the notice of denial after the voluntary internal appeal level.

Upon receipt of a request for an external review, Medical Mutual will review the request for completeness and eligibility. If the request is complete and eligible, Medical Mutual will initiate an external review. Medical Mutual will notify you in writing that the request is complete and include the following information:

1. name and contact information for the Ohio Department of Insurance;
2. a statement that you may, within 10 business days after the date of receipt of the notice, submit, in writing, additional information for the Ohio Department of Insurance to review.

If the request for review is not complete, Medical Mutual will inform you in writing, including what information is needed to make the request complete. If Medical Mutual denies a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, Medical Mutual will notify you in writing of the reason for the denial and that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance will consider whether the health care service is a covered benefit, except that the Ohio Department of Insurance will not conduct a review unless you have exhausted Medical Mutual's internal appeal process. Medical Mutual will provide the Ohio Department of Insurance any information required by the Ohio Department of Insurance that is in Medical Mutual's possession and germane to the review. Unless the Ohio Department of Insurance is not able to do so because making the determination requires a medical judgment or a determination based on medical information, the Ohio Department of Insurance will determine whether the health care service at issue is a covered benefit. The Department will provide notice of the determination. If the Ohio Department of Insurance determines that the health

care service is a covered service, the Plan will cover the service. If the Department determines that the health care service is not a covered service, the Plan is not required to cover the service or provide an external review by an independent review organization.

If the Department notifies Medical Mutual that making the determination requires a medical judgment or a determination based on medical information, Medical Mutual will initiate an external review by an independent review organization.

Review by the Ohio Department of Insurance of Emergency Medical Services Decisions

For an adverse benefit determination in which emergency medical services have been determined to be not medically necessary or appropriate after an external review conducted by an independent review organization, you may request an external review by the Ohio Department of Insurance, based on the prudent layperson standard.

Upon receipt of a request for an external review, Medical Mutual will review the request for completeness and eligibility. If the request is complete and eligible, Medical Mutual will initiate an external review. Medical Mutual will notify you in writing that the request is complete and include the following information:

1. name and contact information for the Ohio Department of Insurance;
2. a statement that you may, within 10 business days after the date of receipt of the notice, submit, in writing, additional information for the Ohio Department of Insurance to review.

If the request for review is not complete, Medical Mutual will inform you in writing, including what information is needed to make the request complete. If Medical Mutual denies a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, Medical Mutual will notify you in writing of the reason for the denial and that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance will provide notice of its determination.

Contact Information for the Ohio Department of Insurance

Ohio Department of Insurance
Consumer Services Division
50 W. Town Street, Third Floor - Suite 300
Columbus, Ohio 43215-4186
Telephone: 800.686.1526

Claim Review

Consent to Release Medical Information - Denial of Coverage

You consent to the release of medical information to Medical Mutual and the Plan when you enroll and/or sign an Enrollment Form.

When you present your identification card for Covered Services, you are also giving your consent to release medical information to Medical Mutual. Medical Mutual has the right to refuse to reimburse for Covered Services if you refuse to consent to the release of any medical information.

Right to Review Claims

When a claim is submitted, Medical Mutual will review the claim to ensure that the service was Medically Necessary and that all other conditions for coverage are satisfied. The fact that a Provider may recommend or prescribe treatment does not mean that it is automatically a Covered Service.

Physical Examination

The Plan may require that you have one or more physical examinations at its expense. These examinations will help to determine what benefits will be covered, especially when there are questions concerning services you have previously received and for which you have submitted claims. These examinations will not have any effect on your status as a Covered Person or your eligibility.

Legal Actions

No action, at law or in equity, shall be brought against Medical Mutual or the Plan to recover benefits within 60 days after Medical Mutual receives written proof in accordance with this Benefit Book that Covered Services have been given to you. No such action may be brought later than three years after expiration of the required claim filing limit as specified in the Proof of Loss section. Actions against the State of Ohio may be required by law to be filed within a shorter time period

Coordination of 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** does not exceed 100% of the total **Allowable expense**.

Definitions

1. 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.
   a. **Plan** includes: group and nongroup 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.
   b. **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 "a" or "b" above 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**.
2. **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.
3. 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**.
4. **Allowable expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an **Allowable expense**.

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

a. 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.
b. If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
c. If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
d. 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.
e. The amount of any benefit reduction by the **Primary plan** because a Covered Person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

5. **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.
6. **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:

1. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.
2. a. Except as provided in Paragraph "b" below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.
   b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
3. 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**.
4. Each **Plan** determines its order of benefits using the first of the following rules that apply:
   a. 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**.
   b. 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:
      1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
         - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
         - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

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

2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a. 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;
   b. 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 (1) above shall determine the order of benefits;
   c. 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 (1) above shall determine the order of benefits; or
   d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      - The **Plan** covering the **Custodial parent**;
      - The **Plan** covering the spouse of the **Custodial parent**;
      - The **Plan** covering the **non-custodial parent**; and then
      - The **Plan** covering the spouse of the **non-custodial parent**.

3. For a dependent child covered under more than one **Plan** of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c. 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 4(a) can determine the order of benefits.

d. 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 4(a) can determine the order of benefits.

e. 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**.

f. 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

1. 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.

2. 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**. Medical Mutual 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. Medical Mutual need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Medical Mutual 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, Medical Mutual 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**. Medical Mutual 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 Medical Mutual 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 attempt to resolve the problem by contacting Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card.

Right of Subrogation and Reimbursement

Subrogation

The Plan reserves the right of subrogation. This means that, to the extent the Plan provides or pays benefits or expenses for Covered Services, the Plan assumes your legal rights to recover the value of those benefits or expenses from any person, entity, organization or insurer, including your own insurer and any under insured or uninsured coverage, that may be legally obligated to pay you for the value of those benefits or expenses. The amount of the Plan's subrogation rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of subrogation shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of subrogation for the total amount the Plan paid for Covered Services is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. This provision is intended to and does reject and supersede the "make-whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of subrogation.

Reimbursement

The Plan also reserves the right of reimbursement. This means that, to the extent the Plan provides or pays benefits or expenses for Covered Services, you must repay the Plan any amounts recovered by suit, claim, settlement or otherwise, from any third party or his insurer and any under insured or uninsured coverage, as well as from any other person, entity, organization or insurer, including your own insurer, from which you receive payments (even if such payments are not designated as payments of medical expenses). The amount of the Plan's reimbursement rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of reimbursement shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of reimbursement for the total amount the Plan paid for Covered Services is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason

of any recovery from any other person or entity. This provision is intended to and does reject and supersede the "make whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of reimbursement.

Your Duties

- You must provide the Plan or its designee any information requested by the Plan or its designee within five (5) days of the request.
- You must notify the Plan or its designee promptly of how, when and where an accident or incident resulting in personal injury to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan or its designee in the investigation, settlement and protection of the Plan's rights.
- You must send the Plan or its designee copies of any police report, notices or other papers received in connection with the accident or incident resulting in personal injury to you.
- You must not settle or compromise any claims unless the Plan or its designee is notified in writing at least thirty (30) days before such settlement or compromise and the Plan or its designee agrees to it in writing.

Discretionary Authority

Medical Mutual shall have discretionary authority to interpret and construct the terms and conditions of the Subrogation and Reimbursement provisions and make determination or construction which is not arbitrary and capricious. Medical Mutual's determination will be final and conclusive.

Changes In Benefits or Provisions

The benefits provided by this coverage may be changed at any time. It is your Group's responsibility to notify you when these changes go into effect. If you are receiving Covered Services under this Benefit Book at the time your revised benefits become effective, the Plan will continue to provide benefits for these services only if they continue to be Covered Services under the revised benefits.

Out of Country Coverage

Your coverage remains in effect when you receive treatment in a foreign country. When you receive medical treatment in another country, you will be asked to pay for the service at the time it is rendered. To receive reimbursement for expenses incurred outside of the United States, the services must be eligible for coverage in accordance with the benefits listed in this Medical Plan Description.

Expenses that are eligible for reimbursement can be submitted by completing a Medical Mutual claim form and attaching the necessary bills. You will need to obtain an itemized bill from the Provider at the time of service. Medical Mutual cannot process a bill unless the Provider lists separately the type and cost of each service you received. To expedite the process, the itemized bill should be written or translated in English. Medical Mutual will determine if the services that were provided are payable according to the benefits. Medical Mutual will then determine the exchange rate for the date of service and pay the claims charges at the out-of-network level unless it is for an emergency. Emergency claims will pay at the network level.

Termination of Coverage

How and When Your Coverage Stops

Your coverage under the terms and conditions, as described in this Benefit Book, stops:

- On the date under the terms and conditions of the Plan, as described in this Benefit Book, that a Covered Person stops being an Eligible Dependent or if coverage is extended by your Group for Student status, on the date the Student status ends. You are responsible for notifying the Group immediately of any change to the eligibility status of a Student.
- At the end of the month in which a Card Holder becomes ineligible.

- On the last day of the month in which a final decree of divorce, annulment or dissolution of the marriage is filed, a Card Holder's spouse will no longer be eligible for coverage under the Plan.
- Immediately upon notice if:
  - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
  - a Covered Person materially misrepresents a material fact provided to the Group or Medical Mutual or commits fraud or forgery.

Certificate of Creditable Coverage

If any Covered Person's coverage would end and the Agreement is still in effect, you and your covered Eligible Dependents will receive a certificate of Creditable Coverage that shows your period of coverage under the Plan.

Federal Continuation Provisions - COBRA

If any Covered Person's group coverage would otherwise end as described above and your employer's group health plan is still in effect, you and your Eligible Dependents may be eligible for continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA is a federal law that allows Covered Persons to continue coverage under specified circumstances where such group coverage would otherwise be lost. To continue coverage, you or your Eligible Dependents must apply for continuation coverage and pay the required premium before the deadline for payment. COBRA coverage can extend for 18, 29 or 36 months, depending on the particular "qualifying event" which gave rise to COBRA.

When You Are Eligible for COBRA

If you are a Card Holder and active employee covered under your employer's group health plan, you have the right to choose this continuation coverage if you lose your group health coverage because of reduction in your hours of employment or termination of employment (for reasons other than gross misconduct on your part) or at the end of a leave under the Family and Medical Leave Act.

If you are the covered spouse of a Card Holder (active employee for number 5 below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the employer's plan for any of the following reasons:

1. the death of your spouse;
2. the termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. divorce or legal separation from your spouse;
4. your spouse becomes entitled (that is, covered) under Medicare; or
5. your spouse is retired, and your spouse's employer filed for reorganization under Chapter 11 of the Bankruptcy Code, and your spouse was covered by the Plan on the date before the commencement of bankruptcy proceeding and was retired from the Group.

In the case of an active employee, or Eligible Dependent of a Card Holder covered by the Plan, he or she has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

1. the death of the Card Holder;
2. the termination of the Card Holder's employment (for reasons other than gross misconduct) or reduction in the Card Holder's hours of employment;
3. the Card Holder's divorce or legal separation;
4. the Card Holder becomes entitled (that is, covered) under Medicare;
5. the dependent ceases to be an "Eligible Dependent;" or
6. the Card Holder is retired and the Card Holder's group files for reorganization under Chapter 11 of the Bankruptcy Code.

Notice Requirements

Under COBRA, the Card Holder or Eligible Dependent has the responsibility to inform the Group of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of any such event. If notice is not received within that 60-day period, the dependent will not be entitled to choose continuation coverage. When the Group is notified

that one of these events has happened, the Group will, in turn, have 14 days to notify the affected family members of their right to choose continuation coverage. Under COBRA, you have 60 days from the date coverage would be lost because of one of the events described above or the date of receipt of notice, if later, to inform your Group of your election of continuation coverage.

If you do not choose continuation coverage within the 60-day election period, your group health coverage will end as of the date of the qualifying event.

If you do choose continuation coverage, your Group is required to provide coverage that is identical to the coverage provided by the Group to similarly situated active employees and dependents. This means that if the coverage for similarly situated Covered Persons is modified, your coverage will be modified.

How Long COBRA Coverage Will Continue

COBRA requires that you be offered the opportunity to maintain continuation coverage for 18 months if you lost coverage under the Plan due to the Card Holder's termination (for reasons other than gross misconduct) or reduction in work hours. A Card Holder's covered spouse and/or Eligible Dependents are required to be offered the opportunity to maintain continuation coverage for 36 months if coverage is lost under the Plan because of an event other than the Card Holder's termination or reduction in work hours.

If, during an 18-month period of coverage continuation, another event takes place that would also entitle a qualified beneficiary (other than the Card Holder) to his own continuation coverage for up to 36 months from the date of entitlement (for example, the former Card Holder dies, is divorced or legally separated, becomes entitled to Medicare or the dependent ceased to be an Eligible Dependent under the Plan), the continuation coverage may be extended for the affected qualified beneficiary. However, in no case will any period of continuation coverage be more than 36 months.

If you are a former employee and you have a newborn or adopted child while you are on COBRA continuation and you enroll the new child for coverage, the new child will be considered a "qualified beneficiary." This gives the child additional rights such as the right to continue COBRA benefits even if you die during the COBRA period. Also, this gives the right to an additional 18-month coverage if a second qualifying event occurs during the initial 18-month COBRA period following your termination or retirement. If you are entitled to 18 months of continuation coverage and if the Social Security Administration determines that you were disabled within 60 days of the qualifying event, you are eligible for an additional 11 months of continuation coverage after the expiration of the 18-month period. To qualify for this additional period of coverage, you must notify the group within 60 days after becoming eligible for COBRA or receiving a disability determination from the Social Security Administration, whichever is later. Such notice must be given before the end of the initial 18 months of continuation coverage. If the individual entitled to the disability extension has non-disabled family members who are qualified beneficiaries and have COBRA coverage, those non-disabled beneficiaries will also be entitled to this 11-month disability extension. During the additional 11 months of continuation coverage, the premium for that coverage may be no more than 150% of the coverage cost during the preceding 18 months.

The law also provides that your continuation coverage may be terminated for any of the following reasons:

1. your Group no longer provides group health coverage to any of its employees;
2. the premium for your continuation coverage is not paid in a timely fashion;
3. you first become, after the date of election, covered under another group health plan (unless that other Plan contains an exclusion or limitation with respect to any preexisting Condition affecting you or a covered dependent); or
4. you first become, after the date of election, entitled (that is covered) under Medicare.

Additional Information

An Eligible Dependent who is a qualified beneficiary is entitled to elect continuation of coverage even if the Card Holder does not make that election. At subsequent open enrollments, an Eligible Dependent may elect a different coverage from the coverage the Card Holder elects.

You do not have to provide proof of insurability to obtain continuation coverage. However, under COBRA, you will have to pay all of the premium (both employer and employee portion) for your continuation coverage, plus a 2% administrative fee. You will have an initial grace period of 45 days (starting with the date you choose continuation coverage) to pay any premiums then due; after that initial 45-day grace period, you will have a grace period of 30 days to pay any subsequent premiums. (During the last 180 days of your continuation coverage period, you must be allowed to enroll in an individual conversion health plan if one is provided by the Group. However, conversion coverage is not available if the Agreement terminates or the Group goes out of business. Call the Group during your last 180 days of COBRA for information on conversion).

It is your Group's responsibility to advise you of your COBRA rights and to provide you with the required documents to complete upon the qualifying event.

Continuation of Coverage During Military Service

If you go on active duty in the U.S. armed forces, you have the right to continue medical coverage for yourself and dependents who were covered under the group medical plan.

This continuation right is concurrent with any right to continue coverage under COBRA. USERRA coverage will end earlier if one of the following events takes place:

1. A premium payment is not made within the required time;
2. You fail to report to work or to apply for reemployment within the time required under USERRA following the completion of your service in the uniformed services; or
3. You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Benefits After Termination of Coverage

If you are an Inpatient of a Hospital or Skilled Nursing Facility on the day your coverage stops, only the benefits listed in the **Inpatient Hospital Services** section under **bed, board and general nursing services** and **ancillary services** will continue. These benefits will end when any of the following occurs:

- the Plan provides your maximum benefits;
- you leave the Hospital or Skilled Nursing Facility;
- the Benefit Period in which your coverage stopped, comes to an end; or
- you have other health care coverage.

This provision applies only to the Covered Services specifically listed in these two subnamed sections. No other services will be provided once your coverage stops.

Rescission of Coverage

A rescission of your coverage means that the coverage may be legally voided all the way 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. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

Federally Eligible Individuals

In addition, you need to be advised of what qualifies you to meet the requirements of a Federally Eligible Individual. Special non-group plans are available to Federally Eligible Individuals. A Federally Eligible Individual is an individual who meets the following requirements:

- an individual must have an 18 month period of Creditable Coverage, with final coverage through a group health plan, including church and governmental plans; health insurance coverage; Part A or Part B of Title XVIII of the Social Security Act (Medicare); the health plan for active military personnel, including TRICARE; the Indian Health Service or other tribal organization program; a state health benefits risk pool; the Federal Employees Health Benefits Program; a public health plan as defined in federal regulations; a health benefit plan under section 5 (c) of the Peace Corps Act; or any other plan which provides comprehensive hospital, medical and surgical services. Coverage after which there was a break of more than 63 days does not count in the period of Creditable Coverage. Creditable Coverage will be counted based on the standard method, without regard to specific benefits.
- an individual must enroll within 63 days of the termination date of your coverage under the group policy coverage;
- an individual must not be eligible for coverage under a group health plan, Medicare or Medicaid;
- an individual must not have other health insurance coverage;
- an individual whose most recent prior coverage has not been terminated for nonpayment of premium or fraud; and

- if the individual elected COBRA coverage or Ohio extension of coverage, the individual must exhaust all such continuation coverage to become a Federally Eligible Individual. Termination for nonpayment of premium does not constitute exhausting such coverage.