MEDICAL MUTUAL®

STATE OF OHIO - OHIO MED PLAN
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228000

PPO Network Comprehensive Major Medical Health Care Benefit Book

Our Member Frequently Asked Questions (FAQ) document is available to help you learn more about your rights and responsibilities; information about benefits, restrictions and access to medical care; policies about the collection, use and disclosure of your personal health information; finding forms to request privacy-related matters; tips on understanding your out-of-pocket costs, submitting a claim, or filing a complaint or appeal; finding a doctor, obtaining primary, specialty or emergency care, including after-hours care; understanding how new technology is evaluated; and how to obtain language assistance. The Member FAQ is available on our member site, *My Health Plan*, accessible from MedMutual.com. To request a hard copy of the FAQ, please contact us at the number listed on your member identification (ID) card.

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SCHEDULE OF BENEFITS

To receive the highest level of benefits at the lowest Out-of-Pocket Maximum expense, Covered Services must be provided by PPO Network Providers. When you use other Providers who are outside of the PPO Network or who are Non-Contracting Providers, you are responsible for any balance due between the Provider's charge and the Allowed Amount, in addition to any Deductibles, Copayments, Coinsurance, and non-covered charges. All benefits are calculated based upon the Allowed Amount, not the Provider's charge. Refer to "How Claims are Paid" for additional information.

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.

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL BENEFIT	
Benefit Period	July 1 to June 30
Dependent Age Limit	The end of the month of the 26th birthday. See "Eligibility" for optional extension to age 28.
PPO Network Deductible per Benefit Period	
If you have single coverage:	$200
If you have family coverage:	$400
Non-PPO Network Deductible per Benefit Period	
If you have single coverage:	$400
If you have family coverage:	$800
PPO Network Coinsurance Limit per Benefit Period	
If you have single coverage:	$1,300
If you have family coverage:	$2,600
	Copayments will accumulate towards the Coinsurance Limit. After the Coinsurance Limit is met you will no longer be required to pay a Copayment.
Non-PPO Network Coinsurance Limit per Benefit Period[1]	
If you have single coverage:	$2,600
If you have family coverage:	$5,200
	Copayments accumulate towards the Coinsurance Limit. After the Coinsurance Limit is met you will no longer be required to pay a Copayment.
PPO Network Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	$1,500
If you have family coverage:	$3,000
Non-PPO Network Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	$3,000
If you have family coverage:	$6,000
Deductible and Out-of-Pocket Maximum Processing [2]	Embedded

[1] Except for Emergency Services received from a Non-Contracting Hospital, there is no Coinsurance Limit with respect to Non-Contracting Institutional Providers' claims. Any amount you pay for non-emergency Covered Services received from a Non-Contracting Institutional Provider will not accumulate towards the Coinsurance Limit. Any Excess Charges you pay for claims will not accumulate towards the Coinsurance Limit.

[2] Under "Embedded processing," the Deductible applicable to single coverage must first be satisfied for at least one Covered Person within a family before Covered Services are payable for that Covered Person. After the Deductible has been met for that Covered Person, the Out-of-Pocket Maximum applicable to single coverage would then apply. Before Covered Services become payable for any other covered Dependents, the Deductible applicable to family coverage must be satisfied. After the family Deductible has been met, the Out-of-Pocket Maximum applicable to family coverage would then apply.

Under "Aggregate processing," expenses for Covered Services incurred by each family member are combined to satisfy the family Deductible and Out-of-Pocket Maximum. Therefore, the entire family Deductible must be satisfied before Covered Services are payable for any Covered Person within the family.

After the applicable Out-of-Pocket Maximum shown above has been met, you are no longer responsible for paying any further Copayments, Deductibles or Coinsurance for Covered Charges Incurred during the balance of the Benefit Period. If the Out-of-Pocket Maximum is unlimited, you continue to be responsible for paying the amounts shown above.

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.

COMPREHENSIVE MAJOR MEDICAL BENEFIT MAXIMUMS PER COVERED PERSON	
(per Benefit Period unless otherwise shown)	
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
Outpatient Occupational Therapy Services	One visit, then subject to medical review
Outpatient Physical Therapy Services	One visit, then subject to medical review
Outpatient Speech Therapy Services	One visit, then subject to medical review
Routine Chest X-Ray and Electrocardiogram (EKG)	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		
TYPE OF SERVICE	**For Covered Services received from a PPO Network Provider, you pay the following portion, based on the Allowed Amount**	**For Covered Services received from a Non-PPO Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (1)**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
Preventive Services in accordance with state and federal law (2)	0%, not subject to the Deductible	40%
Well Child Care Immunizations and Laboratory Services • To age 21	0%, not subject to the Deductible	40%
Well Child Care Office Visits • To age 21	0%, not subject to the Deductible	$30 Copayment, then 40%
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 (4)	40%
Routine PAP Tests	0%, not subject to the Deductible	40%
Routine Mammogram (limited to first mammogram) • Ages 35 and over	0%, not subject to the Deductible (3)	40% (3)
Routine Annual Physical Examinations	0%, not subject to the Deductible	$30 Copayment
Routine Prostate Specific Antigen (PSA) Test (limited to the first PSA Test) • Ages 40 and over	0%, not subject to the Deductible	40%
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 • 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%

COINSURANCE AND COPAYMENTS FOR INSTITUTIONAL AND PROFESSIONAL CHARGES		
TYPE OF SERVICE	**For Covered Services received from a PPO Network Provider, you pay the following portion, based on the Allowed Amount**	**For Covered Services received from a Non-PPO Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (1)**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
EMERGENCY ROOM SERVICES		
The Institutional charge for use of the Emergency Room in an Emergency	$75 Copayment, waived if admitted, then 20%	
All other related Institutional charges	$75 Copayment, waived if admitted, then 20%	
Emergency Room Physician's charges in an Emergency	20%	
The Institutional charge for use of the Emergency Room in a Non-Emergency	$75 Copayment, waived if admitted, then 20%	$75 Copayment, waived if admitted, then 40%
Emergency Room Physician's charges in a Non-Emergency	20%	40%
AUDIOLOGY/HEARING SERVICES		
Assessment for Hearing Aids	$20 Copayment, then 0%	$30 Copayment, then 40%
Hearing Evaluations/Examinations	20%	40%
Hearing Services as a result of Congenital Hearing Loss	20%	40%
Hearing Services - All Other Covered Services as a result of Natural Causes (not an Accident or Illness - $1000 lifetime limit)	50%	
Hearing Services - All Other Covered Services as a result of an Accidental Injury or Illness	20%	40%
HEALTH EDUCATION AND TRAINING SERVICES		
Outpatient Diabetic Education and Training Services	20%, not subject to the Deductible	40%
Outpatient Education and Training for Obesity Services	20%, not subject to the Deductible	40%
Outpatient Nutritional Counseling Services mandated by federal law (limited to two visits)	0%, not subject to the Deductible	40%
Outpatient Nutritional Counseling Services not mandated by federal law (limited to two visits)	20%, not subject to the Deductible	40%
INPATIENT SERVICES		
Initial Newborn Examination	0%, not subject to the Deductible	
Semi-Private Room and Board	20%	40%
Skilled Nursing Facility Services • Up to 180 days per admission	20%, not subject to the Deductible	
Skilled Nursing Facility Services • After 180 days per admission	40%, not subject to the Deductible	
MAMMOGRAM SERVICES		
Medically Necessary Mammograms • To age 35 • Ages 35 and older (after the first Mammogram)	20% (3)	40% (3)
Medically Necessary Mammograms (limited to the first Mammogram) • Ages 35 and older	0%, not subject to the Deductible (3)	40% (3)
PHYSICIAN/OFFICE SERVICES		
Immunizations - Medically Necessary	0%, not subject to the Deductible	40%
Influenza Vaccines received in a Pharmacy	0%, not subject to the Deductible	40%
Medically Necessary Office Visits	$20 Copayment (5)	$30 Copayment, then 40% (5)

COINSURANCE AND COPAYMENTS FOR INSTITUTIONAL AND PROFESSIONAL CHARGES		
TYPE OF SERVICE	**For Covered Services received from a PPO Network Provider, you pay the following portion, based on the Allowed Amount**	**For Covered Services received from a Non-PPO Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (1)**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
Office Visits for the Assessment and Screening of Autism and Developmental Delay	$20 Copayment (5)	$30 Copayment, then 40% (5)
Office Visits for Obesity	20%, not subject to the Deductible	40%
Prenatal Care and Antepartum Care Office Visits	0%, not subject to the Deductible	$30 Copayment, then 40% (5)
Rabies Vaccine	20%	40%
Urgent Care Provider Office Visits	$25 Copayment (5)	$30 Copayment, then 40% (5)
Other Physician/Office Services (in an office or urgent care setting)	20%	40%
OTHER ROUTINE, WELLNESS AND PREVENTIVE SERVICES		
Routine Prostate Specific Antigen Test • To Age 40 • Ages 40 and older (after the first PSA Test)	20%	40%
Routine Therapeutic Injection Administration	0%, not subject to the Deductible	40%
Routine X-ray, Laboratory and Medical Testing Services (Services not previously listed in Preventive Care Services)	20%	40%
Other Preventive Services in accordance with state and federal law	0%, not subject to the Deductible	40%
SURGICAL SERVICES		
Inpatient and Outpatient Surgery	20%	40%
Medically Necessary Outpatient Endoscopic Procedures (i.e, Colonoscopy, Sigmoidoscopy, etc.)	20%	40%
OTHER SERVICES		
Ambulance Services	20%, not subject to the Deductible	
Durable Medical Equipment Services	20%	40%
Home Health Care Services	20%	40%
Hospice Services	0%, not subject to the Deductible	
Outpatient Occupational, Physical and Speech Therapy Services and Chiropractic Visits	20%	40%
All Other Covered Services	20%	40%

Notes

1. **The Coinsurance percentage will be the same for Non-Contracting Providers as Non-PPO Network Providers but you may still be subject to balance billing and/or Excess Charges. Payments to Contracting Non-PPO Network Providers are based on Allowed Amount. Payments to Non-Contracting Providers are based on the Non-Contracting Amount.**
2. Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.
3. Mammograms are limited to the maximum of 130% of the Medicare reimbursement amount for each mammogram.
4. 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.

5. If any of these Covered Services are received from the same Provider on the same day, only one Copayment will be charged per day.

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.

Alcoholism - a Condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as alcohol dependence, abuse or alcoholic psychosis.

Allowed Amount - For PPO Network and Contracting Providers, including Pharmacies, the Allowed Amount is the lesser of the applicable Negotiated Amount or Covered Charge. For Non-Contracting Providers, including non-Network Pharmacies, the Allowed Amount is the Non-Contracting Amount, which will likely be less than the Billed Charges.

Autotransfusion - withdrawal and reinjection/transfusion of the patient's own blood; only the patient's own blood is collected on several occasions over time to be reinfused during an operative procedure in which substantial blood loss is anticipated.

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, and Coinsurance Limits and Out-of-Pocket Maximums 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.

Birth Year - a 12 month rolling year beginning on the individual's birth date.

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, charges are the master charge list uniformly applicable to all payors before any discounts, allowances, incentives or settlements.

Coinsurance - a percentage of the Allowed Amount or Non-Contracting Amount for which you are responsible after you have met your Deductible or paid your Copayment, if applicable.

Coinsurance Limit - a specified dollar amount of Coinsurance expense Incurred in a Benefit Period by a Covered Person for Covered Services.

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

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

Contracting - the status of a 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 for Covered Services, except that Medical Mutual reserves the right to limit the amount of Covered Charges for Covered Services provided by a Non-Contracting Provider to the Non-Contracting Amount determined as payable by Medical Mutual.

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 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);
- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 (Medicaid);
- 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.

Custodial Care - care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting their 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 permanent 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.

Drug Abuse - a Condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as drug dependence abuse or drug psychosis.

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

Eligible Employee - 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.

Emergency Medical Condition - a medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing 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 Services - a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

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 difference between Billed Charges and the applicable Allowed Amount or Non-Contracting Amount. You may be responsible for Excess Charges when you receive services from a Non-Contracting Provider or a non-Network Pharmacy.

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 provided; or
- if reliable evidence shows that the drug, device, medical treatment or procedure is not considered to be the standard of care, 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 is that the drug, device, medical treatment or procedure is not the standard of care and 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 may consist of any one or more of the following:

- published reports and articles in the authoritative medical and scientific literature;
- opinions expressed by expert consultants retained by Medical Mutual to evaluate requests for coverage;
- 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;
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure;
- corporate medical policies developed by Medical Mutual; or
- any other findings, studies, research and other relevant information published by government agencies and nationally recognized organizations.

Even if a drug, device, or portion of a medical treatment or procedure is determined to be Experimental or Investigational, the Plan will cover those Medically Necessary services associated with the Experimental or Investigational drug, device, or portion of a medical treatment or procedure that the Plan would otherwise cover had those Medically Necessary services been provided on a non-Experimental or non-Investigational basis.

The determination of whether a drug, device, medical treatment or procedure is Experimental or Investigational shall be made by the Group and Medical Mutual in their sole discretion, and that determination shall be final and conclusive, subject to any available appeal process.

Full-time Student - an Eligible Dependent who is enrolled at an accredited institution of higher learning. It must be certified annually that the student meets the institution's requirements for full-time status.

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 set forth in the appropriate Chapter 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.

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

Medically Necessary (or Medical Necessity) - a Covered 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.

Negotiated Amount - the amount the Provider has agreed with Medical Mutual to accept as payment in full for Covered Services, subject to the limitations set forth below.

The Negotiated Amount may include performance withholds and/or payments to Providers for quality or wellness incentives that may be earned and paid at a later date. Your Copayment, Deductible and/or Coinsurance amounts may include a portion that is attributable to a quality incentive payment or bonus and will not be adjusted or changed if such payments are not made.

The Negotiated Amount for Providers does not include adjustments and/or settlement due to prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations, performance withhold adjustments or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim. In addition, the Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings (rebates), volume-based credits or refunds or discount guarantees.

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.

Network Pharmacy - a Pharmacy who has a network agreement to provide Prescription Drug services.

Non-Contracting - the status of a Provider that does not have a contract with Medical Mutual or one of its networks.

Non-Contracting Amount - subject to applicable law, the maximum amount allowed by Medical Mutual for Covered Services provided to Covered Persons by a Non-Contracting Provider based on various factors, including, but not limited to, market rates for that service, Negotiated Amounts for that service, and Medicare reimbursement for that service. The Non-Contracting Amount will likely be less than the Provider's Billed Charges. If you receive services from a Non-Contracting Provider, and you are balanced billed for the difference between the Non-Contracting Amount and the Billed Charges, you may be responsible for the full amount up to the Provider's Billed Charges, even if you have met your Out-of-Pocket Maximum.

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

Non-PPO Network Provider - a Provider that does not meet the definition of 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;
- certified dietician;
- certified nurse practitioner;
- clinical nurse specialist;
- 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 professional counselor;
- licensed vocational nurse (L.V.N.);
- mechanotherapist (licensed or certified prior to November 3, 1975);
- nurse-midwife;
- occupational therapist;
- ophthalmologist;
- osteopath;
- Pharmacy;
- physical therapist;
- physician assistant;
- podiatrist;
- Psychologist;
- registered nurse (R.N.);
- registered nurse anesthetist; and
- Urgent Care Provider.

Out-of-Pocket Maximum - a specified dollar amount of Deductible, Coinsurance and Copayment expense, other than those applicable to Prescription Drug benefits, Incurred in a Benefit Period by a Covered Person for Covered Services.

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.

Pharmacy - an Other Professional Provider that is a licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable state law.

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.

PPACA - Patient Protection and Affordable Care Act

PPO Network - a limited panel of Providers as designated by Medical Mutual known as a preferred provider organization.

PPO Network Provider - a 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.

Preauthorization - A decision by Medical Mutual that a health care service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. This is also referred to as "precertification" or "prior approval". Medical Mutual requires preauthorization before you are admitted as an Inpatient in a Hospital or before you receive certain services, except for an Emergency Medical Condition. Preauthorization is not a promise that the Plan will cover the cost.

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

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

Professional - a Physician or Other Professional Provider.

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.

Psychologist - an Other Professional Provider who is a licensed Psychologist having either a doctorate in psychology or a minimum of five years of clinical experience. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

Residential Treatment Facility -

- A facility that provides care on a 24 hour a day, 7 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.
- A facility for residents who do not require care in an acute or more intensive medical setting.

Rider - a document that amends or supplements your coverage.

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.

Specialist - a Physician or group of Physicians, in other than family practice, general practice, geriatrics, internal medicine, pediatrics, neonatology, obstetrics, gynecology or advanced practice nurses.

Spouse - Your current legal spouse as recognized by Ohio law.

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.

Substance Abuse - Alcoholism and/or Drug Abuse.

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.

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

- 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 - any Condition, which is not an Emergency Medical Condition, that requires immediate attention.

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

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 23 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
- 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
- A child who is eligible as an employee of the State is not also eligible as the dependent of a parent who is also a State employee.

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

For information regarding eligible changes outside of open enrollment, please go to the State of Ohio's website at: http://das.ohio.gov/benefits and click the link on the right entitled "Change In Status/Qualifying Events Matrix".

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 Prior Approval 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.

Women's Health and Cancer Rights Act Notice

Your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the Customer Service number located on your identification card for more information.

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 for conditions other than Emergency Medical Conditions via ambulance must be certified by your Physician. Transportation services 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 Emergency Medical Condition 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 for Emergency Medical Conditions will also be covered when provided by a professional ambulance service for other than local ground transportation such as air and water 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 Costs administered to a Covered Person participating in any stage of an Approved Clinical Trial, if that care would be covered under the Plan if the Covered Person was not participating in a clinical trial.

In order to be eligible for benefits, the Covered Person must meet the following conditions (number 2 below is not required for cancer clinical trials in Ohio):

1. The Covered Person is eligible to participate in an Approved Clinical Trial, according to the trial protocol with respect to treatment of cancer or other Life-threatening Conditions.
2. Either:
   a. The referring Provider is a PPO Network Provider and has concluded that the Covered Person's participation in such trial would be appropriate based upon the Covered Person meeting the conditions described in "1" above; or
   b. The Covered Person provides medical and scientific information establishing that his or her participation in such trial would be appropriate based upon the Covered Person meeting the conditions described in "1" above.

If the clinical trial is not available from a PPO Network Provider, the Covered Person may participate in an Approved Clinical Trial administered by a Non-Contracting Provider. However, the Routine Patient Costs will be covered at the Non-Contracting Amount, and the Covered Person may be subject to balance billing up to the Provider's Billed Charges for the services.

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or Condition and is described in any of the following:

- A federally funded trial.
- The study or investigation is conducted under an Investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application.

"Life-threatening Condition" means any disease or Condition from which the likelihood of death is probable unless the course of the disease or Condition is interrupted.

"Routine Patient Costs" means all health care services that are otherwise covered under the Plan for the treatment of cancer or other Life-threatening Condition that is typically covered for a patient who is not enrolled in an Approved Clinical Trial.

"Subject of a Clinical Trial" means the health care service, item, or drug that is being evaluated in the Approved Clinical Trial and that is not a Routine Patient Cost.

No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the Approved Clinical Trial;

- A health care service, item, or drug provided solely to satisfy data collection and analysis needs and 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 Approved Clinical Trial;
- An item or drug provided by the Approved Clinical Trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by an entity other than Medical Mutual, including the sponsor of the Approved Clinical Trial;
- A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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 for an Emergency Medical Condition. 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 Medical Condition, 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 Emergency Medical Condition in an Emergency will be covered according to your Schedule of Benefits. Please refer to your Schedule of Benefits for detailed coverage explanation.

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 Covered Person who is a patient with a reduced life expectancy due to advanced illness. 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.

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 Drug 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 Health Education Services

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

Inpatient Hospital Services

You must have each Inpatient admission to a Non-PPO Network Hospital preauthorized 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 preauthorized, 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.

Inpatient Physical Medicine and Rehabilitation Services

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

Maternity Services, including Notice required by the Newborns' and Mothers' Protection Act

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy 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. Please note that neither you nor your Provider is required to obtain prior approval of an Inpatient maternity stay that falls within these time frames.

Physician-directed, follow-up care services are covered after discharge including:

- parent education;
- physical assessments of the mother and newborn;
- assessment of the home support system;
- assistance and training in breast or bottle feeding;
- performance of any Medically Necessary and appropriate clinical tests; and
- any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

Covered Services will be provided whether received in a medical setting or through home health care visits. Home health care visits are only covered if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn 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 Transplant Services

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

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

Additional organ 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 Transplant Preauthorization - In order for an organ transplant to be a Covered Service, the Inpatient stay must be preauthorized. In addition, the proposed course of treatment must be approved by Medical Mutual. In the event you do not obtain preauthorization, 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. 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 - The following services will be Covered Services when they are necessary in order to acquire a legally obtained human organ:

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

Donor Benefits - Benefits necessary for obtaining an organ 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.

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

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

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.

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.

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.

No benefits will be provided for the following therapy services 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, and in no event will treatment be covered if the number of visits exceeds the limit set forth in the Schedule of Benefits, even if it is Medically Necessary.

Chiropractic Visits - The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part, by a chiropractor. 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**.

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.

All occupational therapy services must be performed by a certified, licensed occupational therapist. The plan will cover medically necessary services provided for the treatment of autism spectrum disorders that have been diagnosed by a qualified DO/MD/PHD with expertise and training in autism.

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 a certified, licensed physical therapist. The plan will cover medically necessary services provided for the treatment of autism spectrum disorders that have been diagnosed by a qualified DO/MD/PHD with expertise and training in autism.

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.

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;
- post-laryngectomy;
- following placement of cochlear implant; or
- autism spectrum disorders.

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

Health Education Services - The following are Covered Services:

Behavioral Counseling to Promote a Healthy Diet - Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases.

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, including those with gestational 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.

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
- rabies
- 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.

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 Gynecological Services - The following services are covered:

- mammogram services; and
- PAP tests and associated examinations.

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
- Bone density screenings
- Cholesterol tests

- Chlamydia screenings, limited to pregnant and sexually active women age 24 and younger and for older women who are at an increased risk
- 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
- Hepatitis B virus screenings; limited to pregnant women in their first prenatal visit.
- 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

Well Child Care Services - Coverage for well child care services will be provided for Covered Persons under the age of 21. Coverage for immunizations is also provided for Covered Persons under the age of 21.

Well child care services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination, routine newborn hearing screening and developmental assessment. Vision tests, hearing 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 and appropriate immunizations.

Women's preventive services - These services will be provided in accordance with the age and frequency requirements of the Affordable Care Act, including, but not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; and counseling for contraceptive methods, breastfeeding and domestic violence.

Coverage is provided for FDA-approved contraceptive methods and counseling. Prescribed contraceptive medication will be paid in accordance with any applicable Prescription Drug benefit.

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.

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.**

Smoking Cessation Services

For Covered Persons age 18 and over, benefits are provided for the screening of tobacco use and for smoking cessation programs for those Covered Persons using tobacco.

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 Allowed Amount for the secondary procedures will be half of the Allowed 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 Allowed Amount will be half of the Allowed Amount for the next two most complex procedures. For all other procedures, the Allowed Amount will be one-fourth of the full Allowed 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.

Urgent Care Services

Health problems that require immediate attention which are not Emergency Medical Conditions are considered to be Urgent Care needs. Determination as to whether or not Urgent Care Services are Medically Necessary will be made by Medical Mutual.

Examples of Urgent Care are:

- minor cuts and lacerations;
- minor burns;
- sprains;
- severe earaches or stomachaches;
- minor bone fractures; or
- minor injuries.

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 regarding the Medical Necessity guidelines.

The following criteria are exceptions to Medical Mutual's corporate medical policy:

1. In order to meet the medically supervised weight loss criterion in the bariatric Surgery medical policy, program oversight must be provided by a Physician.
2. The medical policy criterion addressing physical problems severely interfering with function (e.g., joint disease that would be treatable except for the obesity or body size problems; employment or ambulation precluded by obesity) is NOT required for coverage, if other medical policy criteria are met.

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. Not Medically Necessary or do not meet Medical Mutual's policy, clinical coverage guidelines, or benefit policy guidelines.
4. Services received from a member of your immediate family.
5. Services that would be provided free of charge in the absence of insurance.
6. Charges which exceed the Allowed Amount.
7. Services that are not medically necessary or are not classified as preventive services.
8. Services received before the effective date of your contract or services not specifically covered by your contract.
9. Incurred after you stop being a Covered Person except as specified in the Benefits After Termination of Coverage section.
10. For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability or similar laws, even when the Covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.
11. For which benefits are payable under Medicare Parts A, B and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Benefit Book or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Part B, Medical Mutual will calculate benefits as if he or she had enrolled.
12. Received in a military facility for a military service related Condition.
13. 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.
14. 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.
15. Convalescence care.
16. Residential care rendered by a Residential Treatment Facility.
17. Devices simulating natural body contours unless prescribed in connection with a mastectomy.
18. 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.
19. Illness or injury related to declared or undeclared war or by participation in civil disturbance.
20. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion or nuclear accident.
21. Clinic charges that are services billed by a resident, intern or other employee of a hospital or skilled nursing facility.
22. Services for emergency first aid that are rendered in the office, place of business or other facility maintained by the employer.
23. Services for which no claim was submitted within 15 months of the date of service.
24. Charges for mileage costs or for completion of claim forms or for preparation of medical reports.
25. Expenses that are covered under any other State of Ohio insurance program, such as United Behavioral Health.
26. Chest X-rays and preventive care not necessary to the treatment of an illness, injury or disease, unless specifically allowed.
27. For X-ray examinations with no preserved film image or digital record.
28. Local anesthesia when billed separately, and hypnotism used for anesthetic purposes.
29. Elective cosmetic surgery performed only for the purpose of changing or improving appearance.
30. Surgery to correct a deformity or birth defect for psychological reasons where there is no functional impairment.

31. The removal of tattoos.
32. 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.
33. Ordinary bandages and dressings.
34. Vitamins, herbal remedies, dietary or food supplements or non-prescription drugs.
35. Prescription and over the counter drugs, including weight loss drugs.
36. For nutritional supplements.
37. Growth hormones.
38. Routine foot care, except for diabetics.
39. Orthotics, except for diabetics.
40. Treatments, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss, except as specified.
41. 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.
42. 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.
43. Male Contraceptives and over-the-counter birth control without a prescription.
44. 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.
45. Reverse sterilization.
46. 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.
47. The medical treatment of sexual problems not caused by a biological Condition.
48. Transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
49. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.
50. Marital counseling.
51. Dental care, except as noted elsewhere.
52. 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.
53. Eyeglasses or contact lenses, or related examinations, unless necessitated as a result of an injury, illness or disease.
54. Any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).
55. Treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis, unless specified.
56. 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.
57. Services rendered beyond the period of time generally considered necessary for diagnosis of intellectual disability or mental deficiency.
58. Services rendered for a psychiatric condition usually considered to be irremediable, except for the purpose of diagnosis of the condition as being irremediable, except as specified in the "Outpatient Therapy Services" section.
59. Services provided in connection with autism, pervasive developmental disorders or learning disabilities except for the purpose of diagnosis of the condition, except as specified in the "Outpatient Therapy Services" section.

60. 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.
61. Any services rendered primarily for training or educational purposes, self-administered services and services directed toward self-enhancement, except as otherwise specified.
62. 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.).
63. Acupuncture, hypnosis and massage therapy services performed by a Provider who is not a licensed physical therapist.
64. For blood which is available without charge. For Outpatient blood storage services.
65. 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.
66. Water aerobics.
67. For missed appointments, completion of claim forms or copies of medical records.
68. For any oral, written or electronic communications or consultations by a Provider with a Covered Person or another Provider that do not involve in-person contact with the Covered Person.
69. For charges for doing research with Providers not directly responsible for your care.
70. For stand-by charges of a Physician.
71. For any charges not documented in Provider records.
72. Fraudulent or misrepresented claims.
73. 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.
74. 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/member.

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 nurses' or Providers' 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. Except in the absence of legal capacity, no proof can be submitted later than 15 months after services have been received.

If you fail to follow the proper procedures for filing a Claim as described in this Benefit Book, you or your authorized representative, as appropriate, shall be notified of the failure and the proper procedures as soon as possible, but not later than five (5) days following the original receipt of the request. We may notify you orally unless you provide us with a written request to be notified in writing. Notification under this section is only required if both (1) the claim communication is received by the person or department customarily responsible for handling benefit matters and (2) the claim communication names a specific claimant, a specific medical Condition and a specific treatment, service or product for which approval is requested.

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 Providers based on the Allowed Amount. For Non-Contracting Providers, Medical Mutual pays for benefits based on the Non-Contracting Amount that is determined payable by Medical Mutual. 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 Allowed Amount, Non-Contracting Amount or the amount payable for Non-PPO Network Emergency Services described above will not apply toward any Deductible, Out-of-Pocket Maximum or benefit maximum accumulation.

Your Financial Responsibilities

You are responsible for:

- Any Copayment, Deductible and Coinsurance amounts specified in the Schedule of Benefits. Copayments are generally required to be paid at the time of service. Some Providers can determine the amount due for your Deductible and Coinsurance from Medical Mutual and may require payment from you before providing their services.
- Non-Covered Charges.
- Billed Charges for all services and supplies after benefit maximums have been reached.
- Excess Charges for services and supplies rendered by Non-PPO Network and Non-Contracting Providers.
- Billed Charges for services that are not Medically Necessary.
- Incidental charges.

For Covered Services, Medical Mutual will calculate its payment based upon either the Allowed Amount or Non-Contracting Amount.

For Covered Services received from Contracting Providers, the Providers agreed not to bill for any amount of Covered Charges above the Negotiated Amount, except for services and supplies for which Medical Mutual has no financial responsibility due to a benefit maximum.

For Covered Services received from Non-Contracting Providers, Medical Mutual will calculate its payments based upon the Non-Contracting Amount. You may be responsible for Excess Charges up to the amount of the Provider's Billed Charges. You may also be responsible for the Non-PPO Network Coinsurance for Covered Services received from Contracting Non-PPO Network Providers. The Non-PPO Network Coinsurance continues until your Non-PPO Network Coinsurance Limit is reached. Any Excess Charges billed by Non-Contracting Providers DO NOT apply to the Non-PPO Network Coinsurance Limit.

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.

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

Benefit Period Deductible

Each Benefit Period, you must pay the dollar amount(s) shown in the Schedule of Benefits as the Deductible, if applicable, 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.

Only the amount of the Deductible required per Covered Person will be required for Covered Services that result directly from an accident during the Benefit Period in which the accident occurred if two or more Covered Persons in a Card Holder's family are injured in the same accident, and each of the following conditions are met:

- at least two of these Covered Persons receive Covered Services; and
- the Covered Services are Incurred within 90 days after the accident; and
- the combined Allowed Amount for Covered Services for all Covered Persons involved in the accident is at least equal to one Covered Person's Deductible.

You will not be required to pay two Deductibles if two family members are involved in the same accident and the above criteria is met.

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.

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 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 and whether a Deductible or Coinsurance will also apply.

Deductible and Out-of-pocket Credit

When Medical Mutual is replacing other group health insurance coverage, credit will be given for the satisfaction or partial satisfaction of Deductible and out-of-pocket amounts incurred and applied during the same or overlapping Benefit Period of the previous carrier's plan during the 90 days preceding the effective date of this coverage.

Schedule of Benefits

The Deductible(s) and Out-of-Pocket Maximum(s) that may apply will renew each Benefit Period. Some of the benefits offered in this Benefit Book have maximums.

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.

Provider Status and Direction of Payment

Medical Mutual has agreed to make payment directly to PPO Network and Contracting Providers 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, and benefit maximums, if applicable, will be calculated based upon the Allowed Amount, 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 that 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, or Non-Contracting, is not a statement about their abilities.

Prior Approval 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 approved in advance by Medical Mutual, benefits will be provided as if the Covered Services were provided by a PPO Network Provider. However, that Provider may not accept our Allowed Amount as payment in full, and you may have to pay the Excess Charges.

To obtain prior approval of 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;
- 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, subject to any available appeals process. 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 approval in advance of receiving for Covered Services, benefits will be provided as described in the Schedule of Benefits for Covered Services received from a Non-PPO Network Provider.

Preauthorization Notice for Members Residing Outside the State of Ohio

If you reside outside the state of Ohio, you or your Physician should contact Medical Mutual before you receive the service to ensure that your procedure/service is Medically Necessary. If your Physician requests a procedure that is determined, by Medical Mutual, to not be Medically Necessary, you will be responsible for all Billed Charges. If your Physician does not preauthorize the procedure, you should call Customer Service at the telephone number on your identification card for instructions on obtaining preauthorization for Medical Necessity from the Care Management Department of Medical Mutual.

Preauthorization from Medical Mutual must be obtained for Inpatient admissions to a Hospital in order to receive the full benefits specified in the Schedule of Benefits. If the Hospital does not preauthorize the admission, you must obtain preauthorization for the Inpatient admission by calling the Medical Mutual telephone number on your identification card at least two days prior to your admission to the Hospital. In the event preauthorization is not obtained, and your Hospital admission to a Non-Contracting Hospital is determined to not be Medically Necessary, you will be responsible for all Billed Charges for that Hospital stay. Please refer to the Inpatient Hospital Services section of your Benefit Book for additional information.

In the event of an Emergency Admission, the Hospital, you, a family member or your representative must notify Medical Mutual within 48 hours or two working days of admission or as soon as reasonably possible, or you may be responsible for all Billed Charges for that Emergency Admission.

Additional Outpatient tests, procedures and equipment also require preauthorization. Examples of services that may require preauthorization are:

- reconstruction surgeries
- durable medical equipment and devices
- MRI's and PET scans
- therapy
- home health care
- weight loss surgery.

For a complete and current listing, please visit the "Tool" section of MyHealthPlan or contact Customer Service at the phone number shown on your identification card. Be sure to check this listing before services are received, as the information is subject to change.

If your Inpatient stay is for an organ transplant, please review the requirements under the Organ Transplant Services section.

Please refer to the Benefit Determination for Claims section in the General Provisions for additional preauthorization requirements.

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 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. If supporting documentation is required, then payment will be made in accordance with state and federal law. 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.

Foreign Travel

Benefits include coverage for the treatment of Emergency Medical Conditions rendered worldwide. Your coverage is in effect whether your treatment is received in a foreign country or in the United States. When you receive medical treatment

in another country, you may be asked to pay for the service at the time it is rendered. To receive reimbursement for the care provided, make sure 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. All billing submitted for consideration must be translated into the English language and dollar amounts converted to the current rate of exchange.

To receive reimbursement for Hospital and/or medical expenses, the services rendered must be eligible for coverage in accordance with the benefits described in this Benefit Book. If you travel to a foreign country and you receive treatment for an Emergency Medical Condition, Medical Mutual will provide coverage at the PPO Network level.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of Medical Mutual, Medical Mutual will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of Medical Mutual, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of Medical Mutual, disability affecting a significant number of a PPO Network Provider's staff or similar causes, or health care services provided under this Benefit Book are delayed or considered impractical. Under such circumstances, Medical Mutual and PPO Network Providers will provide the health care services covered by this Benefit Book as far as is practical under the circumstances, and according to their best judgment. However, Medical Mutual and PPO Network Providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of Medical Mutual.

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 Card 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 Plan, the Customer Service representative will telephone the Card Holder with the response. If attempts to telephone the Card Holder are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the Card 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, and your complaint is regarding an Adverse Benefit Determination, you may continue to pursue the matter through the appeal process.

Additionally, the Customer Service Representative will notify you of how to file an appeal.

Benefit Determination for Claims (Internal Claims Procedure)

Claims Involving Urgent Care

A **Claim Involving Urgent Care** is a claim for Medical Care or treatment with respect to which the application of the timeframes for making non-Urgent Care determinations (a) could 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*** will be made by an individual acting on behalf of the plan applying the judgment of a prudent lay person who possesses an average knowledge of health and medicine; however, any Physician with knowledge of the claimant's medical Condition can also determine that a claim involves Urgent Care.

If you file a Claim Involving Urgent Care in accordance with Medical Mutual's claim procedures and sufficient 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 sufficient information necessary to make a benefit determination, Medical Mutual will notify you within 24 hours of receipt of the Claim Involving Urgent Care 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, whether adverse or not, 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

If Medical Mutual has approved an ongoing course of treatment to be provided over a period of time or for a number of treatments, any reduction or termination by Medical Mutual of such course of treatment before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination).

If Medical Mutual has approved an ongoing course of treatment to be provided over a period of time or for a number of treatments, any request to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies, and Medical Mutual must notify the claimant of the benefit determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made to Medical Mutual at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

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 sufficient information is received, Medical Mutual will notify you of its benefit determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 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 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 a Claim Involving Urgent Care.

If you file a Post-Service Claim in accordance with Medical Mutual's claim procedures and sufficient information is received, Medical Mutual will notify you of its benefit determination within a reasonable period of time, but not later than 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 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.

Adverse 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 an Adverse Benefit Determination 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 Adverse Benefit Determination;
- reference to the specific plan provision(s) on which the Adverse Benefit Determination 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;
- 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 Adverse 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 Adverse Benefit Determination was 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 an Internal Appeal and External Review

I. Definitions

For the purposes of this "Filing an Internal Appeal and External Review" Section, the following terms are defined as follows:

Adverse Benefit Determination - a decision by a Health Plan Issuer:

- to deny, reduce, or terminate a requested Health Care Service or payment in whole or in part, including all of the following:
  - a determination that the Health Care Service does not meet the Health Plan Issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;
  - a determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
  - a determination that a Health Care Service is not a Covered Service;
  - the imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To Rescind coverage on a Health Benefit Plan.

Authorized Representative - an individual who represents a Covered Person in an internal appeal process or external review process, who is any of the following: (1) a person to whom a Covered Person has given express written consent to represent that person in an internal appeal process or external review process; (2) a person authorized by law to provide substituted consent for a Covered Person; or (3) a family member or a treating health care professional, but only when the Covered Person is unable to provide consent.

Covered Service - please refer to the definition of this term in the Definitions Section in this Benefit Book.

Covered Person - please refer to the definition of this term in the Definitions Section in this Benefit Book.

Emergency Medical Condition - please refer to the definition of this term in the Definitions Section in this Benefit Book.

Emergency Services - please refer to the definition of this term in the Definitions Section in this Benefit Book.

Final Adverse Benefit Determination - an Adverse Benefit Determination that is upheld at the completion of Medical Mutual's mandatory internal appeal process.

Health Benefit Plan - a policy, contract, certificate, or agreement offered by a Health Plan Issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services.

Health Care Services - services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Plan Issuer - an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services under a Health Benefit Plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health Plan Issuer" includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a Health Benefit Plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the Superintendent.

Independent Review Organization - an entity that is accredited to conduct independent external reviews of Adverse Benefit Determinations.

Rescission or to Rescind - a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Stabilize - please refer to the definition of this term in the Definitions Section in this Benefit Book.

Superintendent - the superintendent of insurance.

Utilization Review - a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

II. How to File an Appeal

If you are not satisfied with an Adverse Benefit Determination, you may file an appeal.

There is no fee to file an appeal. Appeals can be filed regardless of the claim amount at issue.

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 for more information about how to file an appeal. You may also write a letter with the following information: Card 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. However, in the case of a claim involving Urgent Care (as described below), a healthcare professional with knowledge of your medical condition may act as your Authorized Representative without a signed and dated statement from you.

III. Internal Appeals Procedure

A. Mandatory Internal Appeal Level

The Plan provides 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 must be filed within 180 days from your receipt of a notice of Adverse Benefit Determination. All requests for appeal may be made by submitting an electronic form, by calling Customer Service or in writing as described above in the How to File 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 judgment. 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 Final Adverse Benefit Determination is issued. You will have an opportunity to respond before our time frame for issuing a notice of Final Adverse Benefit Determination expires. Additionally, if Medical Mutual decides to issue a Final Adverse Benefit Determination based on a new or additional rationale, you will be provided that rationale free of charge before the final notice of Final Adverse Benefit Determination is issued. You will have an opportunity to respond before our timeframe for issuing a notice of Final Adverse Benefit Determination expires.

You will receive continued coverage pending the outcome of the appeals process. For this purpose, Medical Mutual may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review. If Medical Mutual's Adverse Benefit Determination is upheld, you may be responsible for the payment of services you receive while the appeals process was pending.

1. **Types of Mandatory Internal Appeals and Timeframes**
   a. **Appeal of Claim Involving Urgent Care**
      - You, your Authorized Representative or your Provider may request an appeal of a claim involving 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. Appeals of claims involving Urgent Care typically involve those claims for Medical Care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations (1) could seriously jeopardize the life or health of a patient, or 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 as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request to appeal. The expedited appeal process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

   b. **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. The pre-service claim appeal must be decided within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the receipt of the request and must be requested within 180 days of the date you received notice of an Adverse Benefit Determination.

   c. **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 an Adverse Benefit Determination.

2. **Notices of Final Adverse Benefit Determination after Appeal:**

   All notices of a Final Adverse Benefit Determination after 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 Adverse Benefit Determination;
   - reference to the specific plan provision(s) on which the Adverse Benefit Determination 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 Adverse 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;
   - if the Adverse Benefit Determination was 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; and
   - disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance.

B. What Happens After the Mandatory Internal Appeal Level

If your claim is denied at the mandatory internal appeal level, you may be eligible for either the External Review Process by an Independent Review Organization for Adverse Benefit Determinations involving medical judgment or the External Review Process by the Ohio Department of Insurance for contractual issues that do not involve medical judgment. 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 an Adverse Benefit Determination at the mandatory internal appeal level. The Voluntary Internal Level Appeal and External Review Processes are described below.

C. 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. Send or fax your request 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 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 your receipt of the notice of Adverse Benefit Determination after the mandatory internal appeal. 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 judgment. 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.

A claimant may elect to request this voluntary internal level of appeal only after exhaustion of the mandatory internal appeal level.

Upon request, Medical Mutual will provide you sufficient information relating to the voluntary level of appeal to enable you to make an informed judgment about whether to request this voluntary internal level of appeal.

IV. External Review Process

A. Contact Information for Filing an External Review

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

B. Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code, all Health Plan Issuers must provide a process that allows a person covered under a Health Benefit Plan or a person applying for Health Benefit Plan coverage to request an independent external review of an Adverse Benefit Determination. This is a summary of that external review process. An Adverse Benefit Determination is a decision by Medical Mutual to deny a requested Health Care Service or payment because services are not covered, are excluded, or limited under the plan, or the Covered Person is not eligible to receive the benefit.

The Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny Health Benefit Plan coverage or to Rescind coverage.

C. Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The Covered Person does not pay for the external review. There is no minimum cost of Health Care Services denied in order to qualify for an external review. However, the Covered Person must generally exhaust Medical Mutual's mandatory internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

1. **External Review by an IRO**

   A Covered Person is entitled to an external review by an IRO in the following instances:

   - The Adverse Benefit Determination involves a medical judgment or is based on any medical information
   - The Adverse Benefit Determination indicates the requested service is Experimental or Investigational, the requested Health Care Service is not explicitly excluded in the Covered Person's Health Benefit Plan, and the treating physician certifies at least one of the following:
     - Standard Health Care Services have not been effective in improving the condition of the Covered Person

- Standard Health Care Services are not medically appropriate for the Covered Person
- No available standard Health Care Service covered by Medical Mutual is more beneficial than the requested Health Care Service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The Covered Person's treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal, and the Covered Person has filed a request for an expedited internal appeal.
- The Covered Person's treating physician certifies that the Final Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or Health Care Service for which the Covered Person received Emergency Services, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an Adverse Benefit Determination of Experimental or Investigational treatment and the Covered Person's treating physician certifies in writing that the recommended Health Care Service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective Final Adverse Benefit Determinations (meaning the Health Care Service has already been provided to the Covered Person).

2. **External Review by the Ohio Department of Insurance**

   A Covered Person is entitled to an external review by the Department in either of the following instances:

   - The Adverse Benefit Determination is based on a contractual issue that does not involve a medical judgment or medical information.
   - The Adverse Benefit Determination for an Emergency Medical Condition indicates that medical condition did not meet the definition of emergency AND Medical Mutual's decision has already been upheld through an external review by an IRO.

D. Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the Covered Person, or an Authorized Representative, must request an external review through Medical Mutual within 180 days from your receipt of the notice of Adverse Benefit Determination after the mandatory internal appeal level, if you do not request a voluntary internal level appeal. 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 Adverse Benefit Determination after the voluntary internal appeal level.

All requests must be in writing, including by electronic means, except for a request for an expedited external review. Expedited external reviews may be requested orally. The Covered Person will be required to consent to the release of applicable medical records, and sign a medical records release authorization.

If the request is complete and eligible Medical Mutual will initiate the external review and notify the Covered Person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the Covered Person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. Medical Mutual will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete, Medical Mutual will inform the Covered Person in writing and specify what information is needed to make the request complete. If Medical Mutual determines that the Adverse Benefit Determination is not eligible for external review, Medical Mutual must notify the Covered Person in writing and provide the Covered Person with the reason for the denial and inform the Covered Person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by Medical Mutual and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the Health Benefit Plan and all applicable provisions of the law.

E. IRO Assignment

When Medical Mutual initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of Health Care Service. An IRO that has a conflict of interest with Medical Mutual, the Covered Person, the health care provider or the health care facility will not be selected to conduct the review.

F. Reconsideration by Medical Mutual

If you submit information to the Independent Review Organization or the Ohio Department of Insurance to consider, the Independent Review Organization or Ohio Department of Insurance will forward a copy of the information to Medical Mutual. Upon receipt of the information, Medical Mutual may reconsider its Adverse Benefit Determination and provide coverage for the Health Care Service in question. Reconsideration by Medical Mutual will not delay or terminate an external review. If Medical Mutual reverses an Adverse Benefit Determination, Medical Mutual will notify you in writing and the Independent Review Organization will terminate the external review.

G. IRO Review and Decision

The IRO must consider all documents and information considered by Medical Mutual in making the Adverse Benefit Determination, any information submitted by the Covered Person and other information such as; the Covered Person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the Health Benefit Plan, the most appropriate practice guidelines, clinical review criteria used by the Health Plan Issuer or its Utilization Review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by Medical Mutual of a request for a standard review or within 72 hours of receipt by Medical Mutual of a request for an expedited review. This notice will be sent to the Covered Person, Medical Mutual and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review
- The date the Independent Review Organization was assigned by the Ohio Department of Insurance to conduct the external 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
- References to the evidence or documentation, including any evidence-based standards, that were used or considered in reaching its decision

NOTE: Written decisions of an IRO concerning an Adverse Benefit Determination that involves a health care treatment or service that is stated to be Experimental or Investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

H. Binding Nature of External Review Decision

An external review decision is binding on Medical Mutual except to the extent Medical Mutual has other remedies available under state law. The decision is also binding on the Covered Person except to the extent the Covered Person has other remedies available under applicable state or federal law.

A Covered Person may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to Medical Mutual.

I. If You Have Questions About Your Rights or Need Assistance

You may contact Medical Mutual at the Customer Service telephone number listed on your identification card. You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300

Columbus, Ohio 43215-4186
Telephone: 800.686.1526 / 614-644-2673
Fax: 614-644-3744
TDD: 614-644-3745

Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

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 or that it is Medically Necessary.

As part of its review, Medical Mutual may refer to corporate medical policies developed by Medical Mutual (that may be obtained at Medical Mutual's website) as guidelines to assist in reviewing claims.

Medical Mutual may, in its sole discretion, cover services and supplies not specifically covered by the Benefit Book. This applies if Medical Mutual determines such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Covered Person.

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, preauthorization 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 parent'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 not 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.

Termination of Coverage

How and When Your Coverage Stops

Your coverage as described in this Benefit Book, stops:

- When the Card Holder fails to make the required contributions.
- 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 legal separation, 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 intentionally misrepresents a material fact provided to the Group or Medical Mutual or commits fraud or forgery. If your coverage is rescinded, you will be given 30 days' advance written notice, during which time you may request a review of the decision.

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, 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 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 your coverage would otherwise terminate due to a call to active duty from reserve status, you are entitled to continue coverage for yourself and your Eligible Dependents. Your group shall notify you of your right to continue coverage at the time you notify the group of your call to active duty. You must file a written election of continuation with the group and pay the first contribution for continued coverage no later than 31 days after the date on which your coverage would otherwise terminate. Continuation coverage will end on the earliest of the following dates:

- the date you return to reserve status from active military duty;
- the date coverage terminates under the Benefit Book for failure to make timely payment of a required contribution;
- the date the entire Benefit Book ends; or
- the date the coverage would otherwise terminate under the Benefit Book.

Benefits After Termination of Coverage

Your benefits end on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

Rescission of Coverage

A rescission of coverage means that your coverage is retroactively terminated to a particular date, as if you never had coverage under the Plan after the date of termination. 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 may also be rescinded for any period of time for which you did not pay the required contribution to coverage, including COBRA premiums.

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.