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Group Number
228000-201,401

PPO Network Comprehensive Major Medical Health Care Benefit Book

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PPO NETWORK COMPREHENSIVE MAJOR MEDICAL SCHEDULE OF BENEFITS

Benefit Period	July 1 to June 30
PPO Network Deductible per Benefit Period	$200 single / $400 family
Non-PPO Network Deductible per Benefit Period	$400 single / $800 family
Inpatient Copayment per Admission	$350 Copayment for each Non-PPO Network Inpatient admission to a Hospital or Other Facility Provider. The Copayment only applies to Inpatient Institutional Room and Board Services. This Copayment does not apply to Skilled Nursing Facility Services.
Dependent Age Limit	The end of the month of the 19th birthday or the end of the month of the 23rd birthday if the dependent is a Student
Coinsurance Limit	$1,300 single / $2,600 family
Non-PPO Network Coinsurance Limit	$2,600 single / $5,200 family
PPO Network Out-of-Pocket Maximum per Benefit Period	$1,500 single / $3,000 family The Out-of-Pocket Maximum includes the amount of PPO Network Deductible expense, PPO Network Coinsurance expense and specified Copayment expense Incurred each Benefit Period
Non-PPO Network Out-of-Pocket Maximum per Benefit Period	$3,000 single / $6,000 family The Out-of-Pocket Maximum includes the amount of Non-PPO Network Deductible expense, Non-PPO Network Coinsurance expense and specified Copayment expense Incurred each Benefit Period

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

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

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

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

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

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

BENEFIT PERIOD MAXIMUMS PER COVERED PERSON	
Home Health Care Services	100 visits
Inpatient Consultations	Two per admission
Outpatient Nutritional Counseling Services	Two visits
Routine Chest X-Ray, Complete Blood Count (CBC), Comprehensive Metabolic Panel, Electrocardiogram (EKG), and Urinalysis (UA)	One each
Routine PAP Tests and Associated Examinations	One test and One examination
Routine Physical Examinations for ages 18 and over	One
Routine Physical Examinations received from a Non-PPO Network Provider	$150

MAXIMUM BENEFIT PAYABLE PER LIFETIME PER COVERED PERSON	
Hearing Evaluations and Examinations, Hearing Aid and Conformity Evaluations, Hearing Aid and the Dispensing and Fitting of Hearing Aid as a result of Natural Causes (not an Accident or Illness)	$1,000
Organ Transplant Services	$1,000,000

PREVENTIVE CARE SERVICES $0 Copayment Services are not subject to the Benefit Period Deductible		
BENEFITS	**For Covered Services received from a PPO Network Provider you pay the following**	**For Covered Services received from a Non-PPO Network or Non-Contracting Provider you pay the following**
ROUTINE SERVICES		
Well Child Care Services • To age 18	0% of Lesser Amount	0% of Lesser Amount or Covered Charges
Annual Physical Examinations • Ages 18 and over	0% of Lesser Amount	0% of Lesser Amount or Covered Charges (Limited to $150 per Benefit Period)
Cholesterol, Complete Blood Count (CBC), Hemoglobin, Hematocrit, Urinalysis (UA) • Ages 18 and over	0% of Lesser Amount	0% of Lesser Amount or Covered Charges
Blood Glucose Test	0% of Lesser Amount	0% of Lesser Amount or Covered Charges
Fecal Occult Blood Test	0% of Lesser Amount	0% of Lesser Amount or Covered Charges
Prenatal Office Visits	0% of Lesser Amount	0% of Lesser Amount or Covered Charges
Routine Outpatient Endoscopic Procedures: Colonoscopy, Sigmoidoscopy, Anoscopy and Proctosigmoidoscopy only • Ages 50 and over	0% of Lesser Amount (6)	0% of Lesser Amount or Covered Charges (6)
Routine PAP Test and Associated Office Visit	0% of Lesser Amount	0% of Lesser Amount or Covered Charges
Routine Mammogram (limited to first mammogram) • Ages 35 to 40 • Ages 40 and over	0% of Lesser Amount (3)	0% of Lesser Amount or Covered Charges (3)
Routine Prostate Specific Antigen (PSA) Test • Ages 40 and over	0% of Lesser Amount	0% of Lesser Amount or Covered Charges
Routine Immunizations (Non-Well Child) • Covered for All Ages, except as specified in the Routine and Wellness Section	0% of Lesser Amount	0% of Lesser Amount or Covered Charges
Routine Immunizations - Zoster • Ages 60 and over	0% of Lesser Amount	0% of Lesser Amount or Covered Charges

COINSURANCE PAYMENTS	**Institutional and Professional Charges**	**Institutional and Professional Charges**
TYPE OF SERVICE	**For Covered Services received from a PPO Network Provider you pay the following**	**For Covered Services received from a Non-PPO Network or Non-Contracting Provider you pay the following**
EMERGENCY SERVICES		
Emergency - Emergency Room - the Institutional charge for use of the Emergency Room	$75 Copayment, waived if admitted, then 20% of Lesser Amount, subject to Deductible (1)(2)	$75 Copayment, waived if admitted, then 20% of Lesser Amount or Covered Charges, subject to Deductible (1)(2)
Emergency Services - all other related Institutional and Professional charges	20% of Lesser Amount (1)	20% of Lesser Amount or Covered Charges (1)
Non-Emergency - Emergency Room - the Institutional charge for use of the Emergency Room	$75 Copayment, waived if admitted, then 20% of Lesser Amount, subject to Deductible (2)	$75 Copayment, waived if admitted, then 40% of Lesser Amount or Covered Charges, subject to Deductible (2)

COINSURANCE PAYMENTS	Institutional and Professional Charges	Institutional and Professional Charges
TYPE OF SERVICE	**For Covered Services received from a PPO Network Provider you pay the following**	**For Covered Services received from a Non-PPO Network or Non-Contracting Provider you pay the following**
Non-Emergency Services - all other related Institutional and Professional charges	20% of Lesser Amount	40% of Lesser Amount or Covered Charges
HEALTH EDUCATION AND TRAINING SERVICES		
Outpatient Diabetic Education and Training Services	20% of Lesser Amount, not subject to Deductible	20% of Billed Charges, not subject to Deductible
Outpatient Education and Training for Obesity Services	20% of Lesser Amount, not subject to Deductible	20% of Billed Charges, not subject to Deductible
Outpatient Nutritional Counseling Services	20% of Lesser Amount, not subject to Deductible	20% of Billed Charges, not subject to Deductible
INPATIENT SERVICES		
Initial Newborn Examination	0% of Lesser Amount, not subject to Deductible	0% of Lesser Amount or Covered Charges, not subject to Deductible
Semi-Private Room and Board	20% of Lesser Amount	$350 Copayment, then 40% of Lesser Amount or Covered Charges
Skilled Nursing Facility Services • Up to 180 days per admission	20% of Lesser Amount, not subject to Deductible	20% of Lesser Amount or Covered Charges, not subject to Deductible
Skilled Nursing Facility Services • After 180 days per admission	40% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges, not subject to Deductible
MAMMOGRAM SERVICES		
First Medically Necessary or Routine Mammogram with a high risk diagnosis • Ages Birth to 35	20% of Lesser Amount, not subject to Deductible (3)	40% of Lesser Amount or Covered Charges (3)
First Medically Necessary or Routine Mammogram • Ages 35 to 40	0% of Lesser Amount, not subject to Deductible (3)	0% of Lesser Amount or Covered Charges, not subject to Deductible (3)
First Medically Necessary or Routine Mammogram • Ages 40 and over	0% of Lesser Amount, not subject to Deductible (3)	0% of Lesser Amount or Covered Charges, not subject to Deductible (3)
All Subsequent Routine Mammograms	0% of Lesser Amount, not subject to Deductible (3)	40% of Lesser Amount or Covered Charges (3)
All Subsequent Medically Necessary Mammograms	20% of Lesser Amount (3)	40% of Lesser Amount or Covered Charges (3)
PHYSICIAN/OFFICE SERVICES		
After Hours Care rendered by Urgent Care or Clinic Providers	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges
Immunizations - Medically Necessary	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges
Immunizations - Routine	0% of Lesser Amount, not subject to Deductible	0% of Lesser Amount or Covered Charges, not subject to Deductible
Immunizations - Zoster • Ages 40 to 60	20% of Lesser Amount	40% of Lesser Amount or Covered Charges
Medically Necessary Office Visits	$20 Copayment, then 0% of Lesser Amount (4)(5)	$30 Copayment, then 40% of Lesser Amount or Covered Charges (4)(5)
Office Visits for Obesity	20% of Lesser Amount, not subject to Deductible	20% of Billed Charges, not subject to Deductible
Prenatal Care and Antepartum Care Office Visits	0% of Lesser Amount, not subject to Deductible	0% of Lesser Amount or Covered Charges, not subject to Deductible
Urgent Care Provider Office Visits	$25 Copayment, then 0% of Lesser Amount (4)(5)	$30 Copayment, then 40% of Lesser Amount or Covered Charges (4)(5)
ROUTINE, WELLNESS AND PREVENTIVE SERVICES		
Routine Outpatient Endoscopic Procedures: Colonoscopy, Sigmoidoscopy, Anoscopy and Proctosigmoidoscopy only • Ages 0-50	20% of Lesser Amount (6)	40% of Lesser Amount or Covered Charges (6)
Routine Therapeutic Injection Administration	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges
Routine X-ray and Medical Testing Services	20% of Lesser Amount	40% of Lesser Amount or Covered Charges

COINSURANCE PAYMENTS	Institutional and Professional Charges	Institutional and Professional Charges
TYPE OF SERVICE	**For Covered Services received from a PPO Network Provider you pay the following**	**For Covered Services received from a Non-PPO Network or Non-Contracting Provider you pay the following**
SURGICAL SERVICES		
Inpatient and Outpatient Surgery	20% of Lesser Amount	40% of Lesser Amount or Covered Charges
Medically Necessary Outpatient Endoscopic Procedures (i.e, Colonoscopy, Sigmoidoscopy, etc.)	20% of Lesser Amount	40% of Lesser Amount or Covered Charges
OTHER SERVICES		
Ambulance Services	20% of Lesser Amount, not subject to Deductible	20% of Lesser Amount or Covered Charges, not subject to Deductible
Hearing Evaluations and Examinations, Hearing Aid and Conformity Evaluations, Hearing Aid and the Dispensing and Fitting of Hearing Aid as a result of Natural Causes (not an Accident or Illness)	50% of Lesser Amount	50% of Lesser Amount or Covered Charges
Hearing Evaluations and Examinations, Hearing Aid and Conformity Evaluations, Hearing Aid and the Dispensing and Fitting of Hearing Aid as a result of an Accidental Injury or Illness	20% of Lesser Amount	40% of Lesser Amount or Covered Charges
Hospice Services	0% of Lesser Amount, not subject to Deductible	0% of Lesser Amount or Covered Charges, not subject to Deductible
Outpatient Allergy Testing Services	$20 Copayment, then 0% of Lesser Amount (4)(5)	$30 Copayment, then 40% of Lesser Amount or Covered Charges (4)(5)
All Other Covered Services	20% of Lesser Amount	40% of Lesser Amount or Covered Charges

Notes

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

1. Services for medical emergencies or accidents must be received within the first 72 hours after a medical emergency or an accident.
2. The Copayment you must pay for these Covered Services will accumulate towards the Coinsurance Limit and the Non-PPO Network Coinsurance Limit. **After the Coinsurance Limit and/or Non-PPO Network Coinsurance Limit is met, you will continue to be required to pay a Copayment for these Covered Services**.
3. Mammograms are limited to a maximum of 130% of the Medicare reimbursement amount for each mammogram.
4. If any of these Covered Services are received from the same Provider on the same day, only one Copayment will be charged per day.
5. The Copayment you must pay for these Covered Services will accumulate towards the Coinsurance Limit and the Non-PPO Network Coinsurance Limit. After the Coinsurance Limit and/or Non-PPO Network Coinsurance Limit is met, you will no longer be required to pay a Copayment for Covered Services.
6. If a diagnosis of a medical Condition is made during the screening (e.g., removal of a polyp), the procedure is no longer considered routine and may be considered a diagnostic procedure under Surgical Services.

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL HEALTH CARE BENEFIT BOOK

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

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

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

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

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

NOTICE: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and Hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.

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

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

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

HOW TO USE YOUR BENEFIT BOOK

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

Benefit Book - this document.

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

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

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

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

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

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

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

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

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

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

Copayment - a dollar amount, if specified in the Schedule of Benefits, that you may or may not be required to pay at the time Covered Services are rendered.

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

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

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

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

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

- the Federal Employees Health Benefits Program;
- a public health plan as defined in federal regulations;
- a health benefit plan under section 5 (c) of the Peace Corps Act; or
- any other plan 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 his or her activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes but is not limited to:

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

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

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

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

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

Emergency - an accidental traumatic bodily injury or other medical Condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

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

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

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

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

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

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

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

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

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by

another facility studying substantially the same drug, device, medical treatment or procedure. Determination will be made by Medical Mutual at its sole discretion and will be final and conclusive, subject to any available appeal process.

Federally Eligible Individual -

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Ambulatory Surgical Facility -** a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a Physician and also includes nursing services.
- **Dialysis Facility -** a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- **Home Health Care Agency -** a facility which meets the specifications of Chapter 3701.88 of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio and which provides nursing and other services as specified in the Home Health Care Services section of this Benefit Book. A Home Health Care Agency is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

- **Hospice Facility -** a facility which provides supportive care for terminally ill patients as specified in the Hospice Services section of this Benefit Book.
- **Skilled Nursing Facility -** a facility which primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a Physician.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.
- Residents do not require care in an acute or more intensive medical setting.

Routine Services - Services not considered Medically Necessary.

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

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

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

Stabilize - the provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your Condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

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 status.

Surgery -

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

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

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

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

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

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

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

ELIGIBILITY

Enrolling for Coverage

Prior to receiving this Benefit Book, you enrolled, and were accepted or approved by your Group for individual coverage or family coverage. For either coverage, you may have 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, or if certain conditions will not be covered during the Preexisting Condition Exclusion Period, if applicable.

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.

Eligible Employee

An Eligible Employee is:

An employee of the Group who meets the eligibility requirements of the Group.

Eligible Dependents

The following people are eligible to enroll as dependents:

1. **Spouse**
   - Your current legal spouse as recognized by Ohio law.
2. **Unmarried Children under Age 19**
   - You and your legal spouse's unmarried children (including legally adopted children, children for whom either has been appointed legal guardian and dependent stepchildren and foster children who normally reside with you until the end of the month in which they reach age 19).
     - *You must complete an Affidavit of Dependent Status (ADM 4729) for foster children and for legal guardianship.*
   - Children of divorced or separated parents who are not residing with you but who you are required by law to support, who are under the age of 19.
3. **Unmarried Children over Age 19**
   - Your unmarried children age 19 or older, who are attending an accredited school and are primarily dependent on you for maintenance and support, are eligible until the end of the month in which they either reach age 23 or cease being a student - whichever occurs first.
     - *Student coverage is not automatic. The State will periodically request proof of school enrollment along with a completed Affidavit of Dependent Status (ADM 4729) form. When you provide this proof, your dependent will continue to be covered. If the requested proof is not provided to the State, their coverage ends on the last day of the birthday month.*
     - *To be considered primarily dependent, the dependent must receive the majority of his/her essentials such as food, clothing and shelter from the employee and must be enrolled in an accredited school. Attendance at an accredited school may be either full-time or part-time. Students are permitted to miss one quarter/semester per school year and still retain their coverage.*
     - *You must also provide a copy* of your most recent tax return showing the child as a claimed dependent.
   - Under all health plans, coverage for your dependents ends no later than the last day of the month in which they turn 23, unless they have been granted an extension as described below.
4. **Unmarried Children Incapable of Self-Care**
   - Unmarried children of any age 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. 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 an Affidavit of Dependent Status (ADM 4729) and a Request to Extend Limiting Age for Mentally Retarded, Severely Mentally Ill, or Physically Handicapped Dependent Child (ADM 4730) and give these to your payroll or personnel officer. The forms must be completed and returned no later than 31 days prior to the dependent's 19th birthday, or upon being diagnosed with a disabling condition between the ages of 19 and 23. Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.*

5. **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.
6. **Stepchildren**
   - Current stepchildren living in the employee's home more than 50 percent of the time.
7. **Children of Divorced Parents**
   - Dependents of divorced State of Ohio employees may be enrolled on both parents' family plan pursuant to a court order or joint custody agreement. However, health plans do not allow duplicate payments for services and may not coordinate benefits. Check details with your plan(s).
8. **Married State Employees with Legally Separate Dependents**
   - In cases of two state employees who are married and who have legally separate dependents, the employee who has coverage as a spouse may be included as a covered dependent as well as children not residing with the employee, but for whom the spouse is required by law to provide health insurance. (e.g. a natural child or children that either state employee had from a prior relationship.)

Examples of Persons NOT Eligible for Coverage as a Dependent:

- A spouse from whom the employee is legally divorced or legally separated
- Dependents age 19 to 23 not enrolled in an accredited school who are capable of self-support
- A spouse or child currently in the military service
- Children age 23 or older who are not disabled
- Married children
- 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.)
- Common law spouse in which the relationship began after October 10, 1991
- A child who is eligible as an employee of the state or who receives health care coverage through their own employment
- Current and former stepchildren who do not reside with the employee more than 50 percent of the time
- Any other members of your household who do not meet the definition of an eligible dependent.

Medically Necessary Leave of Absence

If an Eligible Dependent child is being covered as a full-time student, and a Medically Necessary Leave of Absence causes such child to stop being a full-time student under the terms of this Benefit Book, the Eligible Dependent will continue to be covered under this Benefit Book until the earlier of one year, or the date coverage would otherwise end under the terms of this Benefit Book.

Medically Necessary Leave of Absence means a leave of absence from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that:

1. commences while such child is suffering from a serious illness or injury;
2. is Medically Necessary; and
3. causes such child to lose student status for purposes of coverage under the terms of this Benefit Book.

We must receive written certification by the treating Physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is Medically Necessary.

This provision is applicable only to those plans that require student status to continue coverage for a dependent child beyond the dependent age limit, as shown on the Schedule of Benefits.

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 administrator 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 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, because the date this new coverage begins will depend on when you request enrollment.

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

Changes from single to family and family to single may occur if requested within thirty-one (31) days of any of the following events:

1. After marriage, death of a spouse, divorce, legal separation, or annulment, in which case coverage becomes effective the first day of the month following the month of application.
2. Birth, adoption, placement for adoption, or death of a dependent, in which case coverage becomes effective with the birth, adoption, or placement of a child or date of death.
3. Termination or commencement of employment by the employee, spouse or dependent, in which case coverage becomes effective the first day of the month following the month of application.
4. Reduction or increase in hours of employment by the employee (including layoff or reinstatement from layoff), spouse, or dependent, including a switch between part-time and full-time, strike, lockout, or commencement, return to work from an unpaid absence, or change in work site in which case coverage becomes effective the first day of the month following the month of application.
5. Return to work through order of arbitration or settlement of a grievance, or any administrative body with authority to order the return to work of an employee.

6. The employee's dependent satisfies or fails to satisfy the requirement of the definition of dependent due to attainment of age, student status or any similar circumstance as provided in the Health Plan under which the employee receives coverage
7. If the plan receives a Qualified Medical Child Support Order (QMED) pertaining to an employee's dependent, the employee may elect to add or drop the child to the plan depending upon the requirement of the QMED.
8. If an employee, spouse, or dependent who is enrolled in a health plan becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).
9. If an employee, spouse, or dependent is no longer entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

   Requests for changes pursuant to Sections (1) through (9) must be supported by proper documentation.

10. An employee may change health plans if the employee either no longer resides or no longer works in the service area of the employee's current health plan

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.

Your identification card is the property of the Plan and must be returned to the Group if your coverage ends for any reason. After coverage ends, use of the identification card is not permitted and may subject you to legal action.

HEALTH CARE BENEFITS

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

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

Allergy Testing and Treatments

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

Ambulance Services

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

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

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

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

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

Audiology Services

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

One of the following hearing aids will be covered:

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

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

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

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

Case Management

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

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

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

Clinical Trial Programs

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

"Eligible cancer clinical trial" means a cancer clinical trial that meets all of the following criteria:

- A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes;
- The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes;
- The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology; and
- The trial does one of the following:
  - Tests how to administer a health care service, item, or drug for the treatment of cancer;
  - Tests responses to a health care service, item, or drug for the treatment of cancer;
  - Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
  - Studies new uses of a health care service, item, or drug for the treatment of cancer;
  - The trial is approved by one of the following entities:
    - The national institutes of health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
    - The United States Food and Drug Administration;
    - The United States Department of Defense; or
    - The United States Department of Veterans' Affairs.

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

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

No benefits are payable for the following:

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

Contraceptive Services

Your coverage includes benefits for the following contraceptive services:

- contraceptive devices, including but not limited to diaphragms and intrauterine devices (IUDs)

Oral, transdermal, injectable and implantable 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

Benefits for these 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 supplemental prescription drug plan need to be obtained under your Pharmacy coverage.

Durable Medical Equipment

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

Emergency Care Services

You are covered for Medically Necessary Emergency Care following an Emergency. Chronic Conditions are not considered to be Emergencies unless an acute, life-threatening attack occurs. Emergency Care is available 24 hours a day, 7 days a week. If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital to obtain Emergency Services.

Care and treatment once you are Stabilized is not Emergency Care. Continuation of care beyond that needed to evaluate or Stabilize your Condition in an Emergency will be covered according to your Schedule of Benefits. Please refer to your Schedule of Benefits for detailed coverage explanation. Services must be rendered within 72 hours of the accident.

Health Education Services

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

Diabetic Education Services - Outpatient diabetic education services are provided for Covered Persons with a diagnosis of diabetes.

Benefits are only covered when received from the following Provider specialties: general surgery, general practice, family practice, internal medicine, neurology, endocrinology, nephrology, registered dieticians and clinics.

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.

Infertility Services

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

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

- **invitro fertilization**
- **artificial insemination.**

Inpatient Hospital Services

You must have each Inpatient admission to a Non-PPO Network Hospital certified by Medical Mutual in order to receive the full benefits as specified in the Schedule of Benefits. If you have an Inpatient admission to a Non-PPO Network

Hospital which is not certified, you will be required to pay a Deductible of $350. This is called the Preadmission Certification Deductible.

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 Deductible will apply.

The Preadmission Certification Deductible is in addition to any other specified Deductibles. The Preadmission Certification Deductible 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, the primary purpose of which is:

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

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

Maternity Services

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

Coverage for the Inpatient postpartum stay for the mother and the newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a caesarean section. It will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care.

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

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

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

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

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

Medical Care

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

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

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

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

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

Staff consultations required by Hospital rules are not covered.

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

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

Office Visits - Office visits to examine, diagnose and treat a Condition are Covered Services. After Hour Care for Urgent Care and those office visits received from a clinic provider are 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. 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.

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.

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;
- 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 only to improve comfort or appearance. 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

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

Organ and Tissue Transplant Services

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

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

- pancreas; and
- pancreas/kidney

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

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

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

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

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

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

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

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

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

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

Outpatient Institutional Services

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

Covered Institutional services include but are not limited to:

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

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

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

Outpatient Therapy Services

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

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

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

Chiropractic Visits - The treatment given 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**.

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

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

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

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

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

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

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

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

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

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

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

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

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

Physical Medicine and Rehabilitation Services

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

Private Duty Nursing Services

The services of a registered nurse, licensed vocational nurse or licensed practical nurse when ordered by a Physician are covered. These services include skilled nursing services received in a patient's home or as an Inpatient. 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.

Inpatient private duty nursing services include services that Medical Mutual decides are of such a degree of complexity that the Provider's regular nursing staff cannot perform them. 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.

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.

Routine and Wellness Services

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

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

Immunizations - The following immunizations are covered:

- hemophilis influenza B (HEPB-HIB)
- hepatitis A,B, A & B and hepatitis b
- human papillomavirus vaccine (HPV)
- influenza
- MMR (measles, mumps and rubella)
- meningococcal vaccine
- pneumonia
- polio
- rubella
- tetanus toxoid
- varicella (VSV)
- zoster (age 40 and older)

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

Routine Gynecological Services - The following services are covered:

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

Nutritional Counseling Services - Nutritional counseling services are covered when received from the following Provider specialties:

- general practice
- general surgery;
- family practice;
- internal medicine;
- neurology;
- endocrinology;
- nephrology;
- clinics; and
- registered dieticians.

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

- office visits (only covered when received from the following Provider specialties: general surgery, general practice, family practice, internal medicine, neurology, endocrinology, nephrology, registered dieticians and clinics;
- diabetic management programs, including dietician visits;
- nutritional guidance;
- nutritional counseling;
- medical nutrition therapy;
- weight management classes; and
- nutrition classes.

Routine Physical Examinations - Routine physical examinations are covered for Covered Persons 18 years of age and older.

Routine Testing - The following services are covered:

- Blood glucose tests
- Cholesterol tests (covered for ages 18 and older)
- Complete Blood Count (CBC) (covered for ages 18 and older)
- Endoscopic services, meaning: Anoscopy, colonoscopy, proctosigmoidoscopy and sigmoidoscopy, if a diagnosis of a medical Condition is made during a routine screening, (e.g., removal of a polyp), the screening is no longer considered routine and may be payable as a Medically Necessary, diagnostic procedure under the Surgical Services benefits. A Deductible, Copayment and/or Coinsurance may apply.
- Fecal occult blood tests
- Hematocrit tests (covered for ages 18 and older)
- Hemoglobin tests (covered for ages 18 and older)
- Human Papilloma Virus (HPV) tests
- Mammogram services for both men and women (Covered Persons under the age of 35 are covered only if there is a high risk diagnosis)
- Prostate Specific Antigen (PSA) tests (covered for ages 40 and older only)
- Routine x-ray, laboratory and medical testing services
- Urinalysis (UA) (covered for ages 18 and older)

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.

No benefits are provided:

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

Surgical Services

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

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

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

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

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

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

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

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

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

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

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

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

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

Temporomandibular Joint Syndrome Services

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

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

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

Weight Loss Surgery Services

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

EXCLUSIONS

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

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

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

30. Ordinary bandages and dressings.
31. Vitamins, herbal remedies, dietary or food supplements or non-prescription drugs.
32. Prescription and over the counter drugs, including weight loss drugs.
33. Routine foot care, except for diabetics.
34. Orthotics for comfort purposes.
35. Treatments, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss, except as specified.
36. For 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.
37. 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.
38. Contraceptive devices.
39. Contraceptives, except as specified.
40. In vitro fertilization and embryo transplantation, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), assisted reproductive technology (ART) and any costs associated with the collection, preparation or storage of sperm for artificial insemination, including donor fees.
41. Reverse sterilization.
42. Pregnancy Termination. The Ohio Med plans do not provide benefits or services related to non-therapeutic abortions for any State of Ohio employee or dependent. "Non-therapeutic" is defined as an abortion that is performed or induced when the life of the mother would not be endangered if the fetus were carried to term, or when the pregnancy was not the result of rape or incest reported to a law enforcement agency.
43. For the medical treatment of sexual problems not caused by a biological Condition.
44. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
45. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.
46. For marital counseling.
47. Dental care, except as noted elsewhere.
48. For oral implants considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic except when due to trauma, accident or as deemed Medically Necessary by Medical Mutual.
49. Eyeglasses or contact lenses, or related examinations, unless necessitated as a result of an injury, illness or disease.
50. Any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).
51. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.
52. Services rendered principally for care of mental illness (these services are covered by United Behavioral Health).
53. Services rendered beyond the period of time generally considered necessary for diagnosis of mental retardation or mental deficiency.
54. Services rendered for a psychiatric condition usually considered to be irremediable, except for the purpose of diagnosis of the condition as being irremediable.
55. Services provided in connection with autism, pervasive developmental disorders or learning disabilities except for the purpose of diagnosis of the condition.
56. Examinations and procedures performed for screening or testing done without necessity, when not indicated by symptoms or performed for treatment, including pre-marital testing surveys, research, and any procedure performed in connection with a physical examination ordered or required by an employer as a condition of employment or the continuance of employment.
57. Any services rendered primarily for training or educational purposes, self-administered services and services directed toward self-enhancement, except as otherwise specified.

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

GENERAL PROVISIONS

How to Apply for Benefits

Notice of Claim; Claim Forms

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

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

Proof of Loss

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

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

How Claims are Paid

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

Benefit Period Deductible

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

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

Coinsurance

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

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

Copayments

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

Schedule of Benefits

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

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

Your Financial Responsibilities

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

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

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

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

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

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

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

Provider Status and Direction of Payment

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

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

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

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

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

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

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

Pre-Authorization of Non-PPO Network Benefits

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

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

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

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

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

Explanation of Benefits

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

Time of Payment of Claims

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

Filing a Complaint

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on the front of 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, you may continue to pursue the matter through the appeal process.

Filing an Appeal

Expedited Review Process

A request for an expedited review must be certified by your Provider that your Condition could, without immediate medical attention, result in any of the following:

1. seriously jeopardize your life or health or your ability to regain maximum function or with respect to a pregnant woman, place the health of her unborn child in serious jeopardy; 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 does not need to be submitted in writing. Your or your Physician should call the Care Management telephone number on your identification card as soon as possible. Expedited reviews will be resolved within 72 hours after you have submitted the request, with a possibility of extending to five calendar days with good cause. The expedited review process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

Filing an Appeal

If you are not satisfied with a benefit or Medical Necessity determination decision, you may file an appeal. No more than two appeals on one claim will be considered in accordance with the procedures explained below.

To submit an appeal electronically, go to Medical Mutual's Web site, www.MedMutual.com, under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card. You may also write a letter with the following information: 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, 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 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.

You may appeal if your claim is denied because Medical Mutual determined (1) the Services received or requested were not Covered Services or (2) the Services received or requested to be received were not Medically Necessary.

Your Right to an Independent Review for Non-Covered Services by the Ohio Department of Insurance

You have the right to request a review by the Ohio Department of Insurance in certain circumstances as described below. You may contact the Ohio Department of Insurance at the following address:

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

If Medical Mutual denied, reduced or terminated coverage for a health care benefit because Medical Mutual determined that the benefit was not covered under your Benefit Book, you have the right to request a review by the Ohio Department of Insurance. If the Ohio Department of Insurance reviews your case and cannot make a determination because it requires resolution of a medical issue, the Department will notify The Plan of the need to offer you an external review. If the Department of Insurance reviews your case and determines that the health service is a covered benefit, The Plan must either cover the service or allow you the opportunity of an external review.

First Level Mandatory Appeal for Medical Necessity Denial

The Plan offers all Card Holders a first level mandatory appeal. You must complete this first level of appeal before any additional action is taken. First level mandatory appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of benefits. All requests for appeal may be made by submitting an electronic form, by calling Customer Service or in writing as described above.

Under the appeal process, there will be a full and fair review of the claim. 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 appeal will take into account all comments, documents, medical 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 initial benefit determination. All determinations of Medical Necessity that are based in whole or in part on a medical judgment, are made by 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 decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

You may submit written comments, documents, records and other information relating to the claim being appealed. 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 you are appealing.

The appeal procedures are as follows:

Urgent Care Appeal

- You, your authorized representative or your Provider may request an appeal for urgent care. Urgent care claim appeals are typically those claims for Medical Care or treatment where withholding immediate treatment could seriously jeopardize the life or health of a patient or a patient's unborn child, or could affect the ability of the patient to regain maximum functions. The appeal must be decided with 72 hours of the request.

Pre-Service Claim Appeal

- You, your authorized representative or your Provider 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 Benefit Book. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of denial.

Post Service Claim Appeal

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

All notices of a denial of benefit will include the following:

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based.
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the determination, then that information will be provided free of charge upon written request;

- if the claim was denied based on a Medical Necessity or Experimental treatment or similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be provided free of charge upon request;
- upon specific written request from you, 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; and
- your right to bring civil action under federal law following the denial of a claim upon review.

If your claim is denied for Medical Necessity at the first level mandatory appeal, then depending on the type of plan you have and the type of claim, there are two different Second Level Voluntary Appeal Processes. You will be eligible for either the Second Level External Review Process established by the Ohio Department of Insurance OR the Second Level Voluntary Internal Review Process.

Second Level External Review Process by the Ohio Department of Insurance for Medical Necessity Denial

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

1. Medical Mutual has denied, reduced, or terminated coverage for what would be a covered health care service except for the fact that Medical Mutual determined that the service is not Medically Necessary;
2. the proposed service, plus any ancillary services and follow-up care, will cost you $500.00 or more if it is not covered; and
3. you have exhausted the mandatory internal appeal process.

You are NOT entitled to External Review if:

1. The Ohio Department of Insurance determined that the health care service is not a Covered Service under your Benefit Book; or
2. You have already had an external review for the same adverse determination and no new pertinent clinical information has been submitted.

External Review will be conducted by independent review organizations accredited by the Ohio Department of Insurance. You will not be required to pay for any part of the cost of the external review. The Plan is required by law to provide to the independent review organization conducting the review, a copy of the records that are relevant to your medical Condition and the external review.

External Review for Non-Urgent Care Claims Appeals

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to Medical Mutual's Member Appeals Unit at the address listed above. It can be made by you or your Provider. Your Provider may not, however, request an external review without your prior written consent. A request must be accompanied by written certification from your Provider that the proposed service, plus any ancillary services and follow-up care, will cost you $500 or more if the proposed service is not covered by the Plan.

The review panel will issue a written decision within 30 days after you have submitted the request. This written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. The Plan will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Benefit Book.

External Review for Urgent Care Claim Appeals

A request for an external review for Urgent or Expedited claims may be requested orally or electronically with a written confirmation not later than five days after the request in submitted. A request for an expedited review should be made by contacting the Care Management Department at the number on the back of your identification card. It can be made by you or your Provider. Your Provider, may not, however, request an external review without your prior written consent.

A request for an expedited review must be certified by your Provider that your Condition could, without immediate medical attention, result in any of the following:

1. seriously jeopardize your life or health or your ability to regain maximum function or, with respect to a pregnant woman, place the health of her unborn child in serious jeopardy; 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 review panel will issue a written decision within seven calendar days after you have submitted the request. This written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. The Plan will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Benefit Book.

External Review Process for Terminal Conditions

If you have a terminal Condition, you are eligible to have an external review if you meet all of the following criteria:

1. you have a terminal Condition that, according to the current diagnosis of your Physician, has a high probability of causing death within two years; and
2. your Physician certifies that one of the following situations applies to your terminal Condition:
   a. standard therapies have not been effective in improving your Condition;
   b. standard therapies are not medically appropriate for you;
   c. no standard therapy, covered by the Plan, is more beneficial than a therapy recommended by your Physician or requested by you; and
3. your Physician has recommended a drug, device, procedure, or other therapy that your Physician certifies, in writing, is likely to be more beneficial to you, in the Physician's opinion, than standard therapies, or you have requested a therapy found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same Condition; and
4. you have been denied coverage by Medical Mutual for the drug, device, procedure or other recommended or requested therapy and have exhausted all internal appeals; and
5. the drug, device, procedure or other recommended or requested therapy would be a Covered Service except for Medical Mutual's determination that the drug, device, procedure or other therapy is Experimental or Investigational.

You must request the review in writing unless your Physician determines that the therapy would be significantly less effective if not started immediately. You will not be required to pay for any part of the cost of the external review. The review panel will issue a written decision within seven calendar days after you have submitted the request. This written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. The Plan will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Benefit Book.

Second Level Voluntary Internal Appeal

Unless your Group requires you to use an alternative dispute resolution procedure, if your first level mandatory appeal is denied, and you do not qualify for an External Review by the Ohio Department of Insurance, because the cost to you is less than $500, then you have the option of a voluntary second 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 first level of appeal.

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

The voluntary second level of 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 first level mandatory appeal. All determinations of Medical Necessity, that are based in whole or in part on medical judgment, are made by 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 decisions about your care and will not be a subordinate of the professional who made the initial determination of your appeal.

Department of Administrative Services (DAS) Appeal

After all other appeal options have been exhausted, you should submit additional written comments, documents, records, dental X-rays, photographs and other information that were not submitted for the previous appeals.

The request for the appeal must be received by the DAS within 60 days from the receipt of the appeal decision. DAS will complete its review within 60 days from receipt of the request. Send to:

OhioMed Benefit Appeal
Benefits Administration Services
30 East Broad Street, 27th Floor
Columbus, OH 43215

Claim Review

Consent to Release Medical Information - Denial of Coverage

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

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

Right to Review Claims

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

Physical Examination

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

Legal Actions

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

Coordination of Benefits

Coordination of Benefits is the procedure used to pay health care expenses when you or an Eligible Dependent are covered by more than one health care plan. The Plan follows rules established by Ohio law to decide which health care plan pays first and how much the other health care plan must pay. The objective is to make sure the combined payments of all health care plans are no more than your actual bills.

When you or your Eligible Dependents are covered by another group health care plan or an individual plan or policy in addition to this one, the Plan will follow Ohio coordination of benefit rules to determine which health care plan is primary and which is secondary. You must submit all bills first to the primary health care plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary health care plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary health care plan.

The Plan pays for health care only when you follow the Plan's rules and procedures. If the Plan's rules conflict with those of another health care plan, it may be impossible to receive benefits from both health care plans, and you will be forced to choose which health care plan to use.

Plans That Do Not Coordinate Benefits

The Plan will pay benefits without regard to benefits paid by the following kinds of coverage:

- Medicaid;
- Group hospital indemnity coverages which pay less than $100 per day;
- school accident coverage; and
- some supplemental sickness and accident policies.

How the Plan Pays As Primary

- When this Plan is primary, it will pay the full benefit provided by your Benefit Book as if you had no other coverage.

How the Plan Pays As Secondary

- When this Plan is secondary, its payments will be based on the balance left after the primary health care plan has paid. The Plan will pay no more than that balance. In no event will the Plan pay more than it would have paid had this Plan been primary.
- The Plan will pay only for health care services that are covered under this Benefit Book.
- The Plan will pay only if you have followed all of the Plan's procedural requirements, including precertification.
- The Plan will pay no more than the "allowable expense" for the health care involved.

Which Health Care Plan is Primary?

To decide which health care plan is primary, the Plan has to consider both the coordination of benefits provisions of the other health care plan and which member of your family is involved in a claim. The primary health care plan will be determined by the first of the following which applies:

- **Non-coordinating Plan -** If you have another Group plan which does not coordinate benefits, it will always be primary.
- **Employee -** The plan which covers you as an employee (neither laid off nor retired) is always primary.
- **Children (Parents Divorced or Separated) -** If the court decree makes one parent responsible for health care expenses, that parent's plan is primary.

  If the court decree gives joint custody and does not mention health care, the Plan follows the birthday rule as discussed below.

- **Children and the Birthday Rule -** When your children's health care expenses are involved, the Plan follows the "birthday rule." The health care plan of the parent with the first birthday in a calendar year is always primary for the children. For example: If your birthday is in January and your spouse's birthday is in March, your health care plan will be primary for all of your children. In cases where parents have the same birthday, the health plan that has been in effect the longest will be primary.

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

Coordination Disputes

If you believe that the Plan has not paid a Coordination of Benefits claim properly, you should attempt to resolve the problem by contacting Medical Mutual or your Group.

Provision Enforcement

The Plan will coordinate benefits to the extent that the Plan is informed by you or some other person or organization of your coverage under any other health care plan. The Plan is not required to determine if and to what extent you are covered under any other health care plan.

In order to apply and enforce this provision or any provision of similar purpose of any other health care plan, it is agreed that:

- any person claiming benefits described in this Benefit Book will furnish the Plan and/or Medical Mutual with any information the Plan or Medical Mutual needs; and
- the Plan and Medical Mutual may, without the consent of or notice to any person, release to or obtain from any source any necessary information.

Facility of Payment

If payment is made under any other health care plan which the Plan should have made under this provision, then the Plan has the right to pay whoever paid under the other health care plan; the Plan will determine the necessary amount under this provision. Amounts so paid are benefits under this Benefit Book and the Plan is discharged from liability to the extent of such amounts paid for Covered Services.

Right of Recovery

If the Plan pays more for Covered Services than this provision requires, Medical Mutual has the right to recover on behalf of the Plan, the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure the Plan's right to recover the excess payment.

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

- On the date under the terms and conditions of the Plan, as described in this Benefit Book, that a Covered Person stops being an Eligible Dependent or if coverage is extended by your Group for Full-time Student status, on the date the Full-time Student status ends. You are responsible for notifying the Group immediately of any change to the eligibility status of a Full-time Student.
- On the date that a Card Holder becomes ineligible.
- On the day a final decree of divorce, annulment or dissolution of the marriage is filed, a Card Holder's spouse will no longer be eligible for coverage under the Plan.
- Immediately upon notice if:
  - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
  - a Covered Person materially misrepresents a material fact provided to the Group or Medical Mutual or commits fraud or forgery.

Certificate of Creditable Coverage

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

Federal Continuation Provisions - COBRA

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

When You Are Eligible for COBRA

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

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

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

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

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

Notice Requirements

Under COBRA, the Card Holder or Eligible Dependent has the responsibility to inform the Group of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of any such event. If notice is not received within that 60-day period, the dependent will not be entitled to choose continuation coverage. When the Group is notified that one of these events has happened, the Group will, in turn, have 14 days to notify the affected family members of their right to choose continuation coverage. Under COBRA, you have 60 days from the date coverage would be lost because of one of the events described above or the date of receipt of notice, if later, to inform your Group of your election of continuation coverage.

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

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

How Long COBRA Coverage Will Continue

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

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

If you are a former employee and you have a newborn or adopted child while you are on COBRA continuation and you enroll the new child for coverage, the new child will be considered a "qualified beneficiary." This gives the child additional rights such as the right to continue COBRA benefits even if you die during the COBRA period. Also, this gives the right to an additional 18-month coverage if a second qualifying event occurs during the initial 18-month COBRA period following your termination or retirement. If you are entitled to 18 months of continuation coverage and if the Social Security

Administration determines that you were disabled within 60 days of the qualifying event, you are eligible for an additional 11 months of continuation coverage after the expiration of the 18-month period. To qualify for this additional period of coverage, you must notify the group within 60 days after becoming eligible for COBRA or receiving a disability determination from the Social Security Administration, whichever is later. Such notice must be given before the end of the initial 18 months of continuation coverage. If the individual entitled to the disability extension has non-disabled family members who are qualified beneficiaries and have COBRA coverage, those non-disabled beneficiaries will also be entitled to this 11-month disability extension. During the additional 11 months of continuation coverage, the premium for that coverage may be no more than 150% of the coverage cost during the preceding 18 months.

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

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

Additional Information

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

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

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

Continuation of Coverage During Military Service

If you go on active duty in the U.S. armed forces, you will cease to be covered under the regular group health plan as of the end of the month in which you enter active military service. However, you have the following rights to continue coverage:

1. If your military leave period is less than 31 days, you have the right to continue medical coverage for yourself and dependents who were covered under the group medical plan for up to 31 days, at a cost of not more than the cost for a similarly situated active employee.
2. If the military leave period is more than 31 days, you are entitled to continue health coverage for yourself and your dependents who were covered under the group medical plan under the United States Employment and Reemployment Rights Act (USERRA). You may continue coverage under this Act for up to 24 months (or 36 months if any of the following occurs during this 24-month period: death of the reservist; divorce or separation of a reservist from the reservist's spouse; or a child ceasing to be an Eligible Dependent); at 102% of the cost of the coverage. This continuation right is concurrent with any right to continue coverage under COBRA. USERRA coverage will end earlier if one of the following events takes place:
    a. A premium payment is not made within the required time;
    b. You fail to report to work or to apply for reemployment within the time required under USERRA following the completion of your service in the uniformed services; or
    c. You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Benefits After Termination of Coverage

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

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

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

Federally Eligible Individuals

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

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