SG/MMO/OFF DENTAL PLAN 5

Group Number

Dental PPO Network Certificate

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

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DENTAL PPO NETWORK CERTIFICATE

This Certificate describes the dental benefits available to you as part of a Group Contract. It is subject to the terms and conditions of the Group Contract. This is not a summary plan description or an Employee Retirement Income Security Act (ERISA) Plan Document by itself. However, it may be attached to a document prepared by your Group that is called a summary plan description.

The actual Group Contract is between Medical Mutual of Ohio (Medical Mutual) and the employer or organization which pays or forwards the fees. The employer or organization will be referred to as the Group.

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

- apply for coverage under the Group Contract;
- pay for coverage if necessary;
- satisfy the conditions specified in the Eligibility section; and
- be approved by Medical Mutual.

Medical Mutual shall have the right to interpret and apply the terms of this Certificate. The decision about whether to pay any claim, in whole or in part, is within the discretion of Medical Mutual, 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.

Medical Mutual of Ohio (Medical Mutual)

PPO PEDIATRIC DENTAL SCHEDULE OF BENEFITS FOR COVERED PERSONS UNDER AGE 19*

(Benefits are per Covered Person per Benefit Period, unless otherwise stated.)

Benefit Period	Calendar year
Dependent Age Limit	End of the month of the 19th birthday*
Deductible	
PPO Network (see below):	$0
Non-PPO Network:	$100
Out-of-Pocket Maximum (Includes Deductibles and Coinsurance)	
PPO Network (see below):	$0
Non-PPO Network:	Unlimited
Medically Necessary Orthodontic Treatment Deductible	
PPO Network:	$0
Non-PPO Network:	$100

DENTAL PAYMENT SCHEDULE		
Type of Service	**PPO Network Provider**	**Non-PPO Network Provider**
	YOU PAY THE FOLLOWING	
	ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.	
Routine Preventive Services • initial and periodic oral evaluations • bitewing x-rays • prophylaxis • topical fluoride applications • dental sealants (Dental sealants are limited to unrestored permanent molars.) • diagnostic models	0% of Fee Schedule Amount	50% of Fee Schedule Amount
Basic Services • consultations/other evaluations • diagnostic and full mouth/panoramic x-rays • minor restorative services, including, but not limited to, fillings made of amalgam or resin based composites • space maintainers • resin infiltration/smooth surface • veneer repairs • Emergency Palliative Treatments • repairs, relines & adjustments of prosthetics • extractions • impactions • minor oral surgery • general anesthesia	0% of Fee Schedule Amount	60% of Fee Schedule Amount
Major Services • inlays • onlays • core buildup • tooth implantation • endodontic services • periodontal services • crowns • fixed partial dentures (bridges) • dentures (complete & partial)	0% of Fee Schedule Amount	75% of Fee Schedule Amount
Medically Necessary Orthodontic Treatment	0% of Fee Schedule Amount	75% of Fee Schedule Amount

PPO DENTAL SCHEDULE OF BENEFITS
FOR COVERED PERSONS AGES 19* AND OVER

(Benefits are per Covered Person per Benefit Period, unless otherwise stated.)

Benefit Period	Calendar year
Dependent Child Age Limit	End of the month of the 26th birthday.
Deductible	
PPO Network:	$50
Non-PPO Network:	$100
Maximum Benefit	
Combined PPO Network and Non-PPO Network:	$1,000

DENTAL PAYMENT SCHEDULE		
Type of Service	**PPO Network Provider**	**Non-PPO Network Provider**
	YOU PAY THE FOLLOWING	
	ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.	
Routine Preventive Services • initial and periodic oral evaluations • bitewing x-rays • prophylaxis • dental sealants (Dental sealants are limited to unrestored permanent molars.) • diagnostic models	0% of Fee Schedule Amount, not subject to the Deductible	20% of Fee Schedule Amount, not subject to the Deductible
Basic Services • consultations/other evaluations • diagnostic and full mouth/panoramic x-rays • minor restorative services, including, but not limited to, fillings made of amalgam or resin based composites • Emergency Palliative Treatments • repairs, relines & adjustments of prosthetics • extractions • impactions • minor oral surgery • general anesthesia	20% of Fee Schedule Amount	40% of Fee Schedule Amount

BENEFIT MAXIMUMS
FOR COVERED PERSONS UNDER AGE 19*

Type of Service	Maximums
Initial and periodic oral evaluations	Two evaluations per rolling 12 moths
Bitewing x-rays	Two sets per Benefit Period
Full mouth / panoramic x-rays	One every 36 months
Prophylaxis	Two per Benefit Period
Topical fluoride applications	Two per Benefit Period
Dental sealants (Dental sealants are limited to unrestored permanent molars.)	One every 36 months per tooth
Resin infiltration/smooth surface	One every 36 months per tooth for Covered Persons under age 19
Retainer Appliances	One set per arch per course of Orthodontic Treatment
Inlays	Once every five years per tooth
Onlays	Once every five years per tooth
Crowns	Once every five years per tooth
Fixed partial dentures (bridges)	Once every five years per tooth
Dentures (complete and partial)	Once every five years Relining and rebasing is covered if done no less than six months after initial placement but not more than once in any 36-month period. One replacement of a temporary denture if a permanent denture is installed within 12 months of the installment of the temporary denture.

BENEFIT MAXIMUMS
FOR COVERED PERSONS AGES 19* AND OVER

Type of Service	Maximums
Initial and periodic oral evaluations	Two evaluations per rolling 12 months
Bitewing x-rays	Two sets per Benefit Period
Full mouth / panoramic x-rays	One every 36 months
Prophylaxis	Two per Benefit Period
Dental sealants (Dental sealants are limited to unrestored permanent molars.)	One every 36 months per tooth

PREDETERMINATION OF BENEFITS

Required for any Course of Treatment exceeding $200 or involving major restorations.

HOW TO USE YOUR CERTIFICATE

This Certificate describes your dental benefits. Please read it carefully.

The **Schedule of Benefits** gives you information about the limits and maximums of your coverage and explains your Coinsurance 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 Certificate.

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

The **Dental 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 Dental Benefits section.

The **General Provisions** section tells you how to file a claim. 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

Active Treatment - the treatment of adjusting an Orthodontic appliance to apply effective force to the teeth or jaws.

Application - all questionnaires and forms required by Medical Mutual to determine your eligibility.

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

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

Certificate - this document.

Certificate Holder - an eligible employee or participant of the Group who has enrolled for coverage under the terms and conditions of the Group Contract.

Clinically Necessary (Clinical Necessity) - a service or supply that is required to diagnose or treat a Condition and which Medical Mutual determines is:

- appropriate with regard to the standards of good dental practice;
- not primarily for your convenience or the convenience of a Dental Provider; and
- the most appropriate supply or level of service which can be safely provided to you.

Coinsurance - a percentage of the Fee Schedule Amount for Covered Services for which you are responsible after you have met your Deductible.

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

Contract - the agreement between Medical Mutual and your Group referred to as the Group Contract. The Contract includes the Group Application, individual Applications of the Certificate Holders, this Certificate, Schedules of Benefits and any Riders or addenda.

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

Course of Treatment - a planned series of procedures or treatments performed by a Dental Provider.

Covered Charges - the Billed Charges for Covered Services, except that Medical Mutual reserves the right to limit the amount of Covered Charges for Covered Services provided to the Fee Schedule Amount.

Covered Person - the Certificate Holder, and if family coverage is in force, the Certificate Holder's Eligible Dependent(s), as defined in the Eligibility section of this Certificate.

Covered Service - a Dental Provider's service or supply as described in the Dental Benefits section of this Certificate for which Medical Mutual will provide benefits, as listed in the Schedule of Benefits.

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 Medical Mutual will start to provide benefits.

Dental Provider - a Dentist or Physician who provides Covered Services as described in the Dental Benefits section of this document.

Dental Specialist - an oral surgeon, endodontist, periodontist, prosthodontist or orthodontist.

Dentist - a licensed professional who treats diseases and injuries to the teeth and oral cavity.

Domestic Partner (Domestic Partnership) - two adults who have chosen to share their lives in an intimate and committed relationship, reside together and share a mutual obligation of support for the basic necessities of life.

Emergency Palliative Treatment - treatment given in response to a painful or dangerous situation to relieve pain and remove a person from immediate danger without rendering definitive treatment (such as a filling).

Excess Charges - the amount of Billed Charges less Non-Covered Charges in excess of the Fee Schedule Amount.

Experimental or Investigational - a dental service, treatment, device or procedure that is not used universally or accepted by the dental care profession, as determined by Medical Mutual.

Fee Schedule Amount - the maximum dollar allowance for Covered Services that PPO Network Providers have agreed to accept as payment in full. Non-PPO Network Providers will also be reimbursed based on the Fee Schedule Amount.

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

Incurred - the date the service or supply is rendered to you by a Dental 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.

Medically Necessary Orthodontic Treatment - Clinically Necessary Orthodontic treatment that is: 1) rendered by an orthodontist or pediatric dentist to satisfy a demonstrated need for significant functional improvement of the teeth, jaws or related anatomy; 2) not rendered primarily for improvement in appearance; and 3) prescribed within generally accepted clinical standards of Orthodontic practice.

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

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

Non-PPO Network Provider - a Dentist or Physician which is not designated by Medical Mutual as a PPO Network Provider.

Orthodontics - The dental specialty and dental practice that deals with improving alignment of teeth and jaw function using braces and other appliances. Formally, the specialty is known as "Orthodontics and Dentofacial Orthopedics."

Out-of-Pocket Maximum - a specified dollar amount of Deductible, Coinsurance and Copayment expense Incurred in a Benefit Period by a Covered Person for Covered Services.

Periodontal Services - procedures including examination, diagnosis and treatment (including Surgery) of disease affecting the surrounding and supporting tissues of the teeth.

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

PPO Network Provider - a Dentist or Physician designated by Medical Mutual as a PPO Network Provider.

Pre-Determination of Benefits - the method by which Medical Mutual determines Covered Services and how benefits that will be provided for a proposed service or Course of Treatment. For further information, see the How Claims are Paid section.

Retainer Appliance - an intra-oral appliance prescribed by an orthodontist or dental professional to prevent changes in tooth alignment. The retainer may be fixed to the teeth using a dental adhesive rendering it non-removable by the patient. Alternatively, the retainer may be designed to fit securely over or around the teeth while in use but detachable with finger pressure so that is can be removed by the patient. Retainers are often classified as "fixed" or "removable."

Retention Treatment - the period of Orthodontic treatment during which the individual is wearing an appliance to maintain the teeth in position.

Rider - a document that amends or supplements your coverage.

Surgery -

- the performance of generally accepted operative and other invasive procedures of the teeth, bone and soft tissue of the oral structures;
- referring specifically to the operative/cutting procedure of the teeth, bone and soft tissue of the oral structures which are considered within the scope or practice by the provider's license and specialty and/or as determined by the State Dental Board;
- utilized to correct pathology as a result of decay, fracture, damage, loss and infection that would necessitate tissue removal, prosthesis placement, placement of dental materials and medicaments and/or tissue architecture modifications;
- usual and related preoperative and postoperative care; or

- other procedures as reasonably approved by Medical Mutual.

Teledentistry - the delivery of dental services through the use of synchronous, real-time communication and the delivery of services of a dental hygienist or expanded function dental auxiliary pursuant to a dentist's authorization.

ELIGIBILITY

Applying for Coverage

Prior to receiving this Certificate, you applied for individual coverage or family coverage. For either coverage, you completed an Application. There may be occasions when the information on the Application is not enough. Medical Mutual will then request the additional data needed to determine whether or not to approve the enrollment. Coverage will not begin until your enrollment has been approved and you have been given an effective date.

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

Eligible Dependents

An Eligible Dependent is:

- the Certificate Holder's spouse, provided you are not legally separated.
- the Certificate Holder's Domestic Partner;

  To be considered an eligible Domestic Partner, the Certificate Holder and the Domestic Partner:

  - must cohabit and reside together in the same residence, reside together in the same residence for at least six months and intend to do so indefinitely;
  - must be engaged in an exclusive and committed relationship and be financially interdependent;
  - both must at least 18 years of age and be each other's sole Domestic Partner;
  - must not be married or separated from anyone else;
  - must not have had another Domestic Partner within six months of establishing the current domestic partnership;
  - must not be related by blood; and
  - must not be in this relationship solely for the purpose of obtaining benefits coverage.

  The Certificate Holder must provide a Domestic Partner Declaration and a medical history form, with supporting documentation, to Medical Mutual prior to enrolling the dependent Domestic Partner.

- the Certificate Holder's, spouse's or Domestic Partner's:
  - natural children;
  - children placed for adoption and legally adopted children;
  - children for whom either the Certificate Holder, Certificate Holder's spouse or Domestic Partner is the Legal Guardian or permanent Custodian; or
  - any children who, by court order, must be provided health care coverage by the Certificate Holder, Certificate Holder's spouse or Domestic Partner.
- stepchildren, provided the natural parent remains married to the Certificate Holder and resides in the household.

To be considered Eligible Dependents, children's ages must fall within the age limit specified in the Schedule of Benefits.

Eligibility will continue past the age limit for dependent children who are unmarried and primarily dependent upon the Certificate Holder for support due to a physical handicap or intellectual disability which renders them unable to support themselves. This incapacity must have started before the age limit was reached and must be medically certified by a Physician. You must notify Medical Mutual of the dependent child's desire to continue coverage within 31 days of reaching the limiting age. After a two-year period following the date the dependent child meets the age limit, Medical Mutual may annually require further proof that the dependence and incapacity continue.

Qualified Medical Child Support Order

In general, a Qualified Medical Child Support Order (QMCSO) is a court order that requires a Certificate Holder to provide medical and/or dental coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or paternity dispute. A QMCSO 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 any QMCSO as defined by ERISA section 609(a). The Group will promptly notify affected Certificate

Holders and alternate recipients if a QMCSO is received. The Group will notify these individuals of its procedures for determining whether medical child support orders are qualified; within a reasonable time after receipt of such order, the Group will determine whether the order is qualified and notify each affected Certificate Holder and alternate recipient of its determination. A copy of the Group's QMCSO procedures is also available upon request from the Group, without charge.

Once the dependent child is enrolled as an alternate recipient under a QMCSO, the child's appointed guardian will receive a copy of all pertinent information provided to the Certificate Holder. In addition, should the Certificate Holder 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 determined by your Group and Medical Mutual. 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 declare a Domestic Partnership or you or your spouse or Domestic Partner acquire an Eligible Dependent. You must notify your Group benefits administrator who must then notify Medical Mutual of the change.

A spouse and other Eligible Dependents (other than Domestic Partners) who become eligible by reason of marriage will be effective on the date of the marriage if an Application for their coverage is submitted to Medical Mutual within 31 days of the marriage. A newly eligible Domestic Partner may be added only during an open enrollment period.

A newborn child or an adopted child will be covered for 31 days from birth or adoptive placement in the home. If payment of a specific premium is required to provide coverage for an additional child, you must submit an Application to Medical Mutual within 31 days of birth in order to continue coverage beyond 31 days for the additional child. Coverage will continue for the adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

If a premium change (as described above) is required and Medical Mutual is not notified of the change within 31 days of the event, the effective date of your coverage will be determined in accordance with the Group Contract. It is important to complete and submit your Application promptly as the date this new coverage begins will depend on when you apply.

Under Ohio law, certain changes in circumstance (i.e., moving back to Ohio) provide for an additional enrollment opportunity for dependent children. Contact your Group benefits administrator for additional information.

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

Open Enrollment

Each year, your employer is required to offer a 30-day open enrollment period, during which you have the option to renew or change coverage.

Special Enrollment

You or your Eligible Dependent who has declined the coverage provided by this Certificate may enroll for coverage under this Certificate during any special enrollment period if you lose coverage or add a dependent for the following reasons, as well as any other event that may be added by federal regulations:

1. In order to qualify for special enrollment rights because of loss of coverage, you or your Eligible Dependent must have had other group health plan coverage at the time coverage under this Certificate was previously offered. You or your Eligible Dependent must have also stated, in writing, at that time that coverage was declined because of the other coverage, but only if Medical Mutual required such a statement at the time coverage was declined, and you were notified of this requirement and the consequences of declining coverage at that time.
2. If coverage was non-COBRA, loss of eligibility or the Group's contributions must end. A loss of eligibility for special enrollment includes:
    a. Loss of eligibility for coverage as a result of divorce, legal separation or termination of Domestic Partnership
    b. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Certificate)
    c. Death of an Eligible Employee

d. Termination of employment
e. Reduction in the number of hours of employment that results in a loss of eligibility for plan participation (including a strike, layoff or lock-out)
f. Loss of coverage that was one of multiple health insurance plans offered by an employer, and the Eligible Employee elects a different plan during an open enrollment period
g. An individual no longer resides, lives, or works in an HMO Service Area (whether or not within the choice of the individual), and no other benefit package is available to the individual through the other employer
h. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual
i. A situation in which an individual incurs a claim that would meet or exceed a medical plan lifetime limit on all benefits (additional requirements apply)
j. Termination of an employee's or dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)
k. The employee or dependent is determined to be eligible for premium assistance in the Group's plan under a Medicaid or CHIP plan

3. If you or your Eligible Dependent has COBRA coverage, the coverage must be exhausted in order to trigger a special enrollment right. Generally, this means the entire 18, 29 or 36-month COBRA period must be completed in order to trigger a special enrollment for loss of other coverage.
4. Enrollment must be supported by written documentation of the termination of the other coverage with the effective date of said termination stated therein. With the exception of items "j" (termination of Medicaid or CHIP coverage) and "k" (eligibility for premium assistance) above, notice of intent to enroll must be provided to Medical Mutual by the Group no later than thirty-one (31) days following the triggering event with coverage to become effective on the date the other coverage terminated. For items "j" and "k" above, notice of intent to enroll must be provided to Medical Mutual by the Group within sixty (60) days following the triggering event, with coverage to become effective on the date of the qualifying event.

If you acquire a new dependent as a result of entering into a Domestic Partnership, there is no special enrollment period. Newly acquired Domestic Partners may only be added during open enrollment.

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Eligible Dependents, provided that you request enrollment within thirty-one (31) days after the marriage, birth, adoption or placement for adoption.

Your Identification Card

You will receive identification cards. These cards have the Certificate Holder's name, subscriber number and group 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 Medical Mutual 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.

DENTAL BENEFITS

This section describes the services and supplies covered if provided and billed by a Dental Provider. When alternate methods of treatment are available, the allowable amount will be based on the least costly method of treatment that Medical Mutual deems appropriate and Clinically Necessary. All Covered Services must be medically or Clinically Necessary.

Dental coverage includes services provided through Teledentistry, if those services would be covered under this plan when delivered other than through Teledentistry. All other terms and conditions of the Certificate apply.

PEDIATRIC DENTAL BENEFITS FOR COVERED PERSONS UNDER AGE 19

The following are Covered Services:

Preventive Services

- initial and periodic oral evaluations
- bitewing x-rays
- prophylaxis (cleaning)
- topical fluoride applications
- dental sealants, limited to unrestored permanent molars
- diagnostic models

Basic Services

- consultations and other evaluations by a Dental Specialist
- diagnostic x-rays
- full-mouth/panoramic x-rays
- minor restorative services, including, but not limited to, fillings made of amalgam or resin based composites
- space maintainers
- veneer repair
- Emergency Palliative Treatment, including emergency oral evaluations
- repairs, relines and adjustments of prosthetics (complete and partial dentures, crowns, fixed partial dentures (bridges))
- extractions, including simple and surgical extractions, impactions
- minor oral Surgery, including alveoloplasty (Surgery performed on the alveolar bone, including flap entry and closure) and vestibuloplasty
- general anesthesia for a covered oral or dental Surgery

Major Services

- endodontic procedures, including pulpotomy, root canal treatment and apicoectomy (removal of the apex of the tooth root)
- Periodontal Services, including removal of gum tissue around the necks of the teeth and the recontouring of the gum tissue
- inlays
- onlays
- resin infiltration
- core buildup
- tooth reimplantation
- crowns that are not part of a fixed partial denture, including stainless steel crowns
- prosthetics, including complete dentures, fixed partial dentures (bridges), and removable partial dentures, are subject to the following:

- If an appliance can be made serviceable, a replacement appliance is not covered. Refer to the Schedule of Benefits for more details.
- Coverage is limited to standard procedures. Personalized restorations and specialized techniques in constructing dentures or fixed partial dentures are not covered.

Medically Necessary Orthodontic Treatment

Benefits are provided for Orthodontic Treatment, as described in the Schedule of Benefits, only if the treatment is determined to be Medically Necessary. If pre-determination is not obtained, and the treatment is later determined by Medical Mutual to be an uncovered expense or not Clinically or Medically Necessary, you may be responsible for all costs associated with that treatment. Please refer to the General Provision entitled, "Predetermination of Benefits," described later in this Certificate.

Treatment usually consists of Retainer Appliances and tooth straightening appliances, such as braces, or other mechanical aids.

Benefits will be provided only as services are Incurred. When the Covered Person is already receiving Active or Retention Treatment on his or her Effective Date, only services Incurred on or after the Covered Person's Effective Date will be covered, based on a proration of the expected months of treatment.

In addition to the General Exclusions, expenses related to Medically Necessary Orthodontic Treatment that are not covered include:

- Appliance replacement due to patient non-compliance or neglect;
- Medically Necessary Orthodontic Treatment previously performed but that requires re-treatment due to patient non-compliance;
- Additional costs resulting from patient non-compliance (e.g., broken or lost appliances, poor oral hygiene, etc.).

DENTAL BENEFITS FOR COVERED PERSONS AGES 19 AND OVER

The following are Covered Services:

Preventive Services

- initial and periodic oral evaluations
- bitewing x-rays
- prophylaxis (cleaning)
- dental sealants, limited to eligible teeth free from decay or restorations on the occlusal surface

Basic Services

- consultations and other evaluations by a Dental Specialist
- diagnostic x-rays
- full-mouth/panoramic x-rays
- minor restorative services, including, but not limited to, fillings made of amalgam or resin based composites
- Emergency Palliative Treatment, including emergency oral evaluations
- repairs, relines and adjustments of prosthetics (complete and partial dentures, crowns, fixed partial dentures (bridges))
- extractions, including simple and surgical extractions, impactions
- minor oral Surgery, including alveoloplasty (Surgery performed on the alveolar bone, including flap entry and closure) and vestibuloplasty
- general anesthesia for a covered oral or dental Surgery

EXCLUSIONS

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

1. Not prescribed by or performed by or under the direction of a Dental Provider.
2. Not performed within the scope of the Dental Provider's license.
3. Not Clinically Necessary or do not meet Medical Mutual's policy, clinical coverage guidelines, or benefit policy guidelines.
4. For Experimental or Investigational Drugs, Devices, Dental Treatments or Procedures.
5. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
6. For a Condition that occurs as a result of any act of war, declared or undeclared.
7. For which you have no legal obligation to pay in the absence of this or like coverage.
8. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
9. Received from a member of your Immediate Family.
10. Incurred or received prior to your effective date of coverage.
11. Incurred or received after you stop being a Covered Person.
12. For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability or similar laws, even when the Covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.
13. For which benefits are payable under Medicare Parts A, B and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Certificate or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Part B, Medical Mutual will calculate benefits as if he or she had enrolled.
14. Received in a military facility for a military service related Condition.
15. Rendered by more than one Dental Provider. If you change Dental Providers during a Course of Treatment or if more than one Dental Provider treats you for a procedure, additional benefits are not provided.
16. Performed by a Dentist who is compensated by a facility for similar covered services performed for members.
17. For charges in excess of the amount Medical Mutual determines to be allowable.
18. For state or territorial taxes on dental services performed.
19. For fraudulent or misrepresented claims.
20. For missed appointments, completion of claim forms, or copies of medical records.
21. For Outpatient educational, vocational or training purposes except as specified.
22. For congenital or developmental malformation or other services primarily to improve appearance.
23. Resulting from your failure to comply with professionally prescribed treatment.
24. For appliances or restorations needed to increase or restore the vertical dimension or to restore and/or correct the occlusion.
25. For the repair of a damaged space maintainer or damaged orthodontic appliances.
26. For the replacement of lost, stolen or misplaced space maintainers, dentures or other appliances.
27. For duplicate, provisional and temporary devices, appliances and services.
28. For dental implants, unless determined Clinically Necessary by Medical Mutual for Covered Persons under age 19 only.
29. For space maintainers for Covered Persons age 19 and over.
30. For gold foil restorations.
31. For nitrous oxide.

32. For personalized restorations, specialized techniques in constructing dentures or partial fixed dentures or replacement of appliances that can be made serviceable.
33. For Temporomandibular Joint Syndrome (TMJ) services.
34. For instruction for plaque control, oral hygiene and diet.
35. For Major Services for Covered Persons age 19 and over, including dentures.
36. Orthodontic Treatment, except Medically Necessary Orthodontic Treatment for Covered Persons under age 19, unless an Orthodontics Rider that provides Orthodontic Treatment coverage for Covered Persons ages 19 and over is included with this Certificate.
37. For non-covered services or services specifically excluded in the text of this Certificate.

GENERAL PROVISIONS

How to Apply for Benefits

Notice of Claim; Claim Forms

A claim must be filed for you to receive benefits. All PPO Network Providers and many Non-PPO Network 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 Dental Provider. If your Dental Provider does not have a claim form, Medical Mutual will send you one. Call or notify Medical Mutual, in writing, within 20 days, or as soon as reasonably possible, after receiving your first Covered Service and we will send you a form, or you may print a claim form by going to www.medmutual.com/member.

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

Proof of Loss

Proof of loss is a claim for payment of dental 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 a Dental 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 unless written or electronically submitted proof that Covered Services have been given to you is received. Proof must be given within 90 days of your receiving Covered Services or as soon as is reasonably possible. Except in the absence of legal capacity, no proof can be submitted later than one year from the time proof is otherwise required.

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

How Claims are Paid

Your Financial Responsibilities

For Covered Services, Medical Mutual will calculate its payment based upon the Fee Schedule Amount.

You are responsible for:

- Any Copayment, Deductible and Coinsurance amounts specified in the Schedule of Benefits. Copayments are generally required to be paid at the time of service.
- Non-Covered Charges.
- Billed Charges for all Services and supplies after benefit maximums have been reached.
- Excess Charges for services and supplies if your Dental Provider does not accept the Fee Schedule Amount as payment in full.
- Services that are not Clinically Necessary.
- Incidental charges.
- Charges for more expensive treatment or services when there are alternate methods of treatment available.

For Covered Services, Medical Mutual will calculate its payment based upon the Fee Schedule Amount. PPO Network Providers have agreed not to bill for any amount of Covered Charges above the Fee Schedule Amount. For Covered Services rendered by Non-PPO Network Providers, you may be responsible for Excess Charges up to the amount of the Provider's Billed Charges. You may also be responsible for the Non-PPO Coinsurance for Covered Services received from Non-PPO Network Providers. Any Excess Charges billed by Non-PPO Network Providers DO NOT apply to any Out-of-Pocket Maximum.

In cases where there are alternate methods of treatment with different fees, and the more expensive treatment or service is rendered, you are responsible for all charges in excess of the allowable amount deemed appropriate and Clinically Necessary by Medical Mutual, even if a PPO Network Provider is used. If the services are provided by a Non-PPO Network Provider, you may be responsible to pay the difference between the charges for the higher level of service and the benefits Medical Mutual will provide for the lower level of service. If you receive services from a Non-PPO and Medical Mutual has not received Pre-Determination of Benefits, you may be responsible for the entire cost of the services provided.

Deductibles, Coinsurance and amounts paid by other parties do not accumulate towards the benefit maximums or any Out-of-Pocket Maximums.

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 Medical Mutual will begin to provide benefits. This is the amount of expense that must be Incurred and paid by you for Covered Services before Medical Mutual 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, Medical Mutual 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.

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 your Schedule of Benefits. The amount of Coinsurance you have to pay may vary depending on the status of your Dental Provider.

Copayments

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

Schedule of Benefits

The Deductibles and Out-of-Pocket Maximums that may apply will renew each Benefit Period. Some of the benefits offered in this Certificate have maximums.

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

Direction of Payment

Medical Mutual has agreed to make payment directly to PPO Network Providers. The choice of a Dental Provider is yours. After a Dental Provider performs a Covered Service, Medical Mutual will not honor your request to withhold claim payment. Medical Mutual does not furnish Covered Services but only pays for Covered Services you receive from Dental Providers. Medical Mutual is not liable for any act or omission of any Dental Provider. Medical Mutual has no responsibility for a Dental Provider's failure or refusal to give Covered Services to you.

Medical Mutual has and retains the sole right to choose which Dental 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 Dental Providers as PPO Network Providers.

Medical Mutual is authorized to make payments directly to Dental 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 Dental Provider and Medical Mutual is not 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 Dental 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, and you must repay this amount when requested.

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

Pre-Determination of Benefits

Pre-Determination of Benefits determines if proposed dental treatments:

- are consistent with the standards of good dental practice;
- are the most appropriate level of service;
- are Clinically Necessary; and for pediatric orthodontic treatment, Medically Necessary; and
- are Covered Services.

After your Dental Provider has examined you, a proposed Course of Treatment (also known as a predetermination) and the diagnostic materials, such as x-rays and study models, that support this Course of Treatment must be provided to Medical Mutual.

For any type of Orthodontic Treatment that may be covered under the plan (refer to the Schedule of Benefits), your proposed Course of Treatment must include the dates of all installations of appliances and all orthodontic services.

Medical Mutual reserves the right to review your dental records, including diagnostic materials, to determine the most appropriate level of service. Medical Mutual may also elect to have you examined by a Dentist or Physician of its choice. Medical Mutual will then notify you and your Dental Provider which services will and will not be covered as requested, as well as the approximate amounts that will be covered. If it is determined that an alternate level of service is as appropriate as the proposed level of service, you and your Dental Provider will be notified, and benefits will be limited to the less costly service, regardless of which level of service is actually rendered (applying alternate benefits). If you select the more costly treatment or service, you are responsible for all charges in excess of the allowable amount deemed Clinically Necessary by Medical Mutual. You are also responsible for Excess Charges if alternate benefits are applied, even if a PPO Network Provider is used. You may be responsible to pay the difference between the charges for the higher level of service and the benefit Medical Mutual will provide for the lower level of service.

If pre-determination is not obtained, and the treatment is later determined by Medical Mutual to be an uncovered expense or not Clinically or Medically Necessary, you may be responsible for all costs associated with that treatment.

If you use a Non-PPO Network Provider, you may be responsible and obligated to pay any and all amounts that you are charged regardless of what Medical Mutual determines to be Clinically Necessary or appropriate.

Medical Mutual evaluates cost-effective alternatives to current dental needs. In such cases, benefits not expressly covered in this Certificate may be approved. Coverage for these services must be approved in advance and in writing by Medical Mutual. Pre-Determination of Benefits does not guarantee payment. The amount payable is subject to all the Contract limitations effective at the time the services are rendered.

Explanation of Benefits

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

Time of Payment of Claims

Benefits will be provided under this Certificate within 30 days after receipt of a completed claim. If supporting documentation is required, then payment will be made in accordance with state and federal law. To have a payment or denial related to a claim reviewed, you must send a written request or call Customer Service at Medical Mutual within 180 days of the claim determination.

Filing a Complaint

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

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

If your complaint is regarding a claim, a Medical Mutual Customer Service representative will review the claim for correctness in processing. If the claim was processed according to terms of the Contract, the Customer Service representative will telephone the Certificate Holder with the response. If attempts to telephone the Certificate Holder are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the Certificate Holder will receive a check, Explanation of Benefits or letter explaining the revised decision.

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

If you are not satisfied with the results and your complaint is regarding an adverse benefit determination, you may continue to pursue the matter through the appeal process.

Benefit Determination for Claims (Internal Claims Procedure)

Claims Involving Urgent Care

A **Claim Involving Urgent Care** is a claim for Dental care or treatment with respect to which the application of the timeframes for making non-urgent care determinations (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (b) in the opinion of a Dentist or Physician with knowledge of the claimant's medical Condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Determination of **urgent** will be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any Dentist or Physician with a knowledge of the claimant's medical Condition can also determine that a claim involves urgent care.

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

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

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

Concurrent Care Claims

If Medical Mutual has approved an ongoing course of treatment to be provided over a period of time or for a number of treatments, any reduction or termination by Medical Mutual of such course of treatment before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination). Medical Mutual will notify the claimant of Medical Mutual's determination to reduce or terminate such course of treatment before the end of the approved period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

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

Pre-Service Claims

A Pre-Service Claim is a claim for a benefit which requires some form of preapproval or precertification by Medical Mutual.

If you file a Pre-Service Claim in accordance with Medical Mutual's claim procedures and sufficient information is received, Medical Mutual will notify you of its benefit determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. Medical Mutual may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of Medical Mutual. Medical Mutual will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, Medical Mutual will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Post-Service Claims

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

If you file a Post-Service Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. Medical Mutual may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of Medical Mutual. Medical Mutual will notify you of such an extension and date by which it expects to render a decision.

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

Benefit Determination Notices

You will receive notice of a benefit determination, orally as allowed, or in writing. 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;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of Medical Mutual's appeal procedures, applicable timeframes, including the expedited appeal process, if applicable;
- notice of your right to bring a civil action under federal law following the denial of a claim after review on appeal, if your group is subject to The Employee Retirement Income Security Act of 1974 (ERISA);
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the adverse benefit determination was based on Medical Necessity, Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

Filing an Appeal

How to File an Appeal

If you disagree with a decision we have made on your claim you may file an appeal. If you are enrolled in My Health Plan you can complete and submit a member appeal form which can be found under Resources and Tools/ Forms/ Member Appeal Form. You can also call Customer Care at the telephone number on your identification card to request a member appeal form or get more information about how to file an appeal. You may also write a letter with the following information: Certificate Holder's full name, patient's full name, identification number, claim number if your appeal is regarding a claim denial or payment, your reason for appealing including why you believe or decision was incorrect, the name of the dental provider and date of service. You may include any supporting information such as medical records or notes you would like considered in your appeal. Mail or fax your appeal to:

Medical Mutual
Member Appeals Department
PO Box 94580
Cleveland, OH 44101-4580
Fax: 216-687-7990

The request for review must come directly from the patient unless he/she is a minor or has appointed an authorized representative. You can choose another person to represent you during the appeal process, as long as Medical Mutual has a signed and dated statement from you authorizing the person to act on your behalf. However, in the case of a claim involving urgent care (as described below), a healthcare professional with knowledge of your medical Condition may act as your authorized representative without a signed and dated statement from you.

Mandatory Internal Appeal

The Plan offers a mandatory internal appeal. You must complete this mandatory internal appeal before any additional action is taken.

Mandatory internal appeals must be filed within 180 days from your receipt of a notice of adverse benefit determination. All requests for appeal may be made by submitting an appeal form, available on My Health Plan, or in writing as described in the How to File an Appeal section above.

Under the appeal process there will be a full and fair review of the claim in accordance with applicable law for this plan. The internal appeal process is a review of your appeal by an Appeals Specialist, a Dentist or Physician consultant and/or other licensed healthcare professional. The review of the appeal will take into account all comments, documents, records and other information submitted by you and the Dental Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

All determinations that involve, in whole or in part, issues of Medical Necessity, whether services are Experimental and Investigational, or any other medical judgment, are based on the evaluations and opinions of health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior evaluations about your claim and will not be a subordinate of the professional who made the initial evaluation of your claim. These health care professionals act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits. Upon specific written request from you, Medical Mutual will provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

You may submit written comments, documents, records 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:

Appeal of a Claim Involving Urgent Care

You, your authorized representative or your Dental Provider may request an appeal of a Claim Involving Urgent Care. The appeal does not need to be submitted in writing. You, your authorized representative, or your Physician should call

the telephone number on your identification card as soon as possible. Appeals of Claims Involving Urgent Care typically involve those claims for Medical Care or treatment with respect to which the application of the time periods for making non-urgent care determinations (1) could seriously jeopardize the life or health of a patient, or could affect the ability of the patient to regain maximum functions, or (2) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The appeal must be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request to appeal. The expedited appeal process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

Pre-Service Claim Appeal

You or your authorized representative may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the plan Benefit Book. The pre-service claim appeal must be decided within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the receipt of the request and must be requested within 180 days of the date you received notice of an adverse benefit determination.

Post Service Claim Appeal

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

All notices of a denial of benefit after an appeal will include the following:

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based;
- sufficient information to identify the claim or health care service involved, including the date of services, the health care provider, and the claim amount (if applicable);
- statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- if the adverse benefit determination was based on a Medical Necessity, Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request;
- a description of applicable appeal procedures; and
- notice of your right to bring a civil action under federal law following the denial of a claim upon review on appeal, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Claim Review

Consent to Release Dental Information - Denial of Coverage

You consent to the release of dental information to Medical Mutual when you sign an Application.

When you present your identification card for Covered Services, you are also giving your consent to release dental 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 dental information.

Right to Review Claims

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

Dental Examination

Medical Mutual may require that you have one or more dental 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 to recover benefits within 60 days after Medical Mutual receives written proof in accordance with this Certificate 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

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

Definitions

1. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   a. **Plan** includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
   b. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under "a" or "b" above is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.
2. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.
3. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan** .

   When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.
4. **Allowable expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not

covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an **Allowable expense**.

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

a. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private Hospital room expenses.
b. If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
c. If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
d. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the Provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
e. The amount of any benefit reduction by the **Primary plan** because a Covered Person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, preauthorization of admissions, and preferred provider arrangements.

5. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.
6. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order Of Benefit Determination Rules

When a person is covered by two or more **Plans** , the rules for determining the order of benefit payments are as follows:

1. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.
2. a. Except as provided in Paragraph "b" below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.
   b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
3. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
4. Each **Plan** determines its order of benefits using the first of the following rules that apply:
   a. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.
   b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order of benefits is determined as follows:
      1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
- If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.
- However, if one parent's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
   b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
   d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      - The **Plan** covering the **Custodial parent**;
      - The **Plan** covering the spouse of the **Custodial parent**;
      - The **Plan** covering the **non-custodial parent**; and then
      - The **Plan** covering the spouse of the **non-custodial parent**.

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

c. Active employee or retired or laid-off employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

d. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

e. Longer or shorter length of coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

f. If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

Effect On The Benefits Of This Plan

1. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense**

for that claim. In addition, the **Secondary plan** shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

2. If a Covered Person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. Medical Mutual may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. Medical Mutual need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Medical Mutual any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Medical Mutual may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. Medical Mutual will not have to pay that amount again. The term " payment made " includes providing benefits in the form of services, in which case " payment made " means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Medical Mutual is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us at 1-800-700-2583 or medmutual.com. In the event our phone number or website changes, refer to your identification card for the most current information. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

Subrogation and Right of Reimbursement

As used herein, the term "Third Party", means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as "Third Party Injuries." "Third Party" includes any party responsible for payment of expenses associated with the care or treatment of Third Party Injuries. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of Medical Mutual.

If this plan pays benefits under this Certificate to you for expenses incurred due to Third Party Injuries, then Medical Mutual retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the Third Party Injuries. Medical Mutual's rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for injuries resulting from an accident, injury or alleged negligence.

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

By accepting benefits under this plan, you specifically acknowledge Medical Mutual's right of subrogation. When this plan pays health care benefits for expenses incurred due to Third Party Injuries, Medical Mutual shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this plan. Medical Mutual may proceed against any party with or without your consent.

By accepting benefits under this plan, you also specifically acknowledge Medical Mutual's right of reimbursement. This right of reimbursement attaches when this plan has paid benefits due to Third Party Injuries and you or your representative has recovered any amounts from a Third Party. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. By providing any benefit under this Certificate, Medical Mutual is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. Medical Mutual's right of reimbursement is cumulative with, and not exclusive of, Medical Mutual's subrogation right and Medical Mutual may choose to exercise either or both rights of recovery.

By accepting benefits under this plan, you and your representatives further agree to:

- Notify Medical Mutual promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by you;
- Cooperate with Medical Mutual and do whatever is necessary to secure Medical Mutual's rights of subrogation and reimbursement under this Certificate;
- Give Medical Mutual a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party Injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due Medical Mutual as reimbursement for the full cost of all benefits associated with Third Party Injuries paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement); and
- Do nothing to prejudice Medical Mutual's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of Third Party Injuries.

Medical Mutual may recover full cost of all benefits paid by this plan under this Certificate without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from Medical Mutual's recovery, and Medical Mutual is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any Third Party. In the event you or your representative fail to cooperate with Medical Mutual, you shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Medical Mutual in obtaining repayment.

If less than the reasonable full value of the third party action is recovered due to comparative negligence on your part, diminishment of the recovery due to the apportionment of liability among and recovery on judgment against multiple co-defendants, or by reason of the collectability of the reasonable full value of the claim for injury, death, or loss to you resulting from limited liability insurance or any other cause, Medical Mutual's claim shall be reduced in the same proportion as your interest is reduced. Medical Mutual shall have the right to seek a declaratory judgment pursuant to ORC Section 2721 if there is a dispute over the distribution of the recovery in a tort action.

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.

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 Certificate at the time your revised benefits become effective, Medical Mutual will continue to provide benefits for these services only if they continue to be Covered Services under the revised benefits.

If the provisions of this Certificate are changed or revised, Medical Mutual will notify the Group 31 days prior to the changes becoming effective. It is the responsibility of the Group to notify the Certificate Holders of the change or revision.

Termination of Coverage

How and When Your Coverage Stops

Your coverage stops:

- By termination of the Group Contract including termination for non-payment. This automatically ends all of your coverage. It is the responsibility of your Group to notify you of such termination.
- On the date that a Covered Person stops being an Eligible Dependent.
- On the date the Certificate Holder becomes ineligible.
- At the end of the period for which the premium was made when a Covered Person does not pay the next required contribution.
- On the day a final decree of legal separation, divorce, annulment or dissolution of the marriage is filed, a Certificate Holder's spouse will no longer be eligible for coverage, subject to any available conversion offer.
- On the date a Certificate Holder's Domestic Partnership terminates, the Domestic Partner will cease to be eligible for coverage.
- Immediately upon notice if:
  - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
  - a Covered Person intentionally misrepresents a material fact provided to Medical Mutual or commits fraud or forgery.

Federal Continuation Provisions - COBRA

Note: Domestic Partners and dependents of Domestic Partners are not eligible for continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). In the sections describing COBRA benefits Eligible Dependents means the Certificate Holder's spouse, and eligible dependent children of the Certificate Holder or the Certificate Holder's spouse.

If any Covered Person's group coverage would otherwise end and your employer's group policy 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 medical and dental 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. Your employer must have a certain number of employees in order to be subject to COBRA.

When You Are Eligible for COBRA

If you are a Certificate Holder and active employee covered under your employer's group health and/or dental plan, you have the right to choose this continuation coverage if you lose your group dental 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 a covered retiree, you have the right to continuation coverage if your employer has filed for reorganization under Chapter 11 of the Bankruptcy Code.

If you are the covered spouse of a Certificate Holder (active employee or retiree for number 5 below) covered by Medical Mutual, you have the right to choose continuation coverage for yourself if you lose group dental coverage under the employer's plan for any of the following five (5) 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 Medical Mutual on the date before the commencement of bankruptcy proceeding and was retired from the group.

In the case of an Eligible Dependent of a Certificate Holder, (active employee or retiree for number six (6) below) covered by Medical Mutual, he or she has the right to continuation coverage if group dental coverage under the employer's plan is lost for any of the following six (6) reasons:

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

Notice Requirements

Under COBRA, the Certificate Holder or Eligible Dependent has the responsibility to inform the group of a divorce, legal separation or a child losing dependent status under Medical Mutual 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 dental 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 group due to the Certificate Holder's termination (for reasons other than gross misconduct) or reduction in work hours. A Certificate 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 group because of an event other than the Certificate 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 Certificate Holder) to his own continuation coverage (for example, the former Certificate Holder dies, is divorced or legally separated, becomes entitled to Medicare or the dependent ceased to be an Eligible Dependent under the Group Contract) 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 Social Security Administration determines that you were disabled within the 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 receiving a disability determination from the Social Security Administration. 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 four (4) reasons:

1. your group no longer provides group dental 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 dental 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 Certificate Holder does not make that election. At subsequent open enrollments, an Eligible Dependent may elect a different coverage from the coverage the Certificate 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.

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

Continuation of Coverage During Military Service

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

- the date you return to reserve status from active military duty;
- 24 months from the date continuation began (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);
- the date coverage terminates under the Certificate for failure to make timely payment of a required contribution;
- the date the entire Certificate ends; or
- the date the coverage would otherwise terminate under the Certificate.

Multi-Language Interpreter Services & Nondiscrimination Notice

This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة:إذاكنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم (711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

Order Number: Z8188-MCA R4/19
Dept of Ins. Filing Number: Z8188-MCA R9/16

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.