FAMILY DENTAL PLAN 1

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 between the Group Insurance Trust and Medical Mutual of Ohio (Medical Mutual). It is subject to the terms and conditions of the Group Contract. The actual Group Contract is between Medical Mutual of Ohio (Medical Mutual) and the Trustee (called the Contract Holder).

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.

Please note that you must pay your premium for this Certificate. Medical Mutual of Ohio (Medical Mutual) does not accept premium payment from any other entity on your behalf, except for Ryan White, Indian tribes and local, state and federal government programs, as required by 45 CFR 156.1250, or as Medical Mutual may specifically agree in writing, provided such payments are otherwise compliant with notice issued by the Department of Health and Human Services (HHS) on February 7, 2014, and other applicable HHS guidance subsequently issued.

Examination Right

This Certificate can be canceled by returning it by mail or in person, within 10 days of having it in your possession, to the address shown below. Any paid premium will be fully refunded.

Medical Mutual of Ohio (Medical Mutual)
100 American Road
Cleveland, Ohio 44144

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.)

IMPORTANT: If you opt to receive dental care services that are not Covered Services under this plan, a Dental Provider may charge you his or her normal fee for such services. Prior to providing you with dental care services that are not Covered Services, the Dental Provider will provide you with an estimated cost for each service.

Please be sure to review the "Pediatric Dental Services" section of this document for a description of the pediatric dental care services and materials that are Covered Services under this plan. You are responsible for any non-Covered Services you elect to receive.

Benefit Period	Calendar year
Covered Persons 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 • 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 • resin infiltration/smooth surface • 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.)

IMPORTANT: If you opt to receive dental care services that are not Covered Services under this plan, a Dental Provider may charge you his or her normal fee for such services. Prior to providing you with dental care services that are not Covered Services, the Dental Provider will provide you with an estimated cost for each service.

Benefit Period	Calendar year
Dependent Age Limit	End of the month of the 26th birthday.
Deductible	
PPO Network:	$100
Non-PPO Network:	$100
Benefit Maximum	
Combined PPO Network and Non-PPO Network:	$2,000

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.)	0% of Fee Schedule Amount, not subject to the Deductible	50% of Fee Schedule Amount
Basic Services - 6 month waiting period • 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	50% of Fee Schedule Amount	75% of Fee Schedule Amount
Major Services - 12 month waiting period • inlays • onlays • endodontic services • periodontal services • crowns • fixed partial dentures (bridges) • dentures (complete & partial)	70% of Fee Schedule Amount	85% of Fee Schedule Amount

BENEFIT MAXIMUMS APPLICABLE TO ALL AGES, UNLESS OTHERWISE STATED

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
Topical fluoride applications	Two per Benefit Period for Covered Persons under age 19
Dental sealants (Dental sealants are limited to unrestored permanent molars.)	One every 36 months per tooth
Space maintainers	For Covered Persons under age 19
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 unit
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.

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 person who adopts and agrees to be bound by the provisions contained in the Trust Agreement and the Group Contract and whose request for coverage of Covered Persons has been accepted by Medical Mutual.

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 the Trustee and Medical Mutual, referred to as the Contract or Group Contract, as may be amended from time to time.

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.

Group - those eligible persons who Medical Mutual has accepted as Certificate Holders under the Group Contract.

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.

Minimum Essential Coverage - the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

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.

Trust Agreement - the agreement between the Trustee and Medical Mutual which established the Group Insurance Trust.

Trustee - the person with whom Medical Mutual has contracted to oversee the Trust Agreement and to whom the Group Contract is issued. The Trustee is the Contract Holder.

ELIGIBILITY

Eligibility Requirements

You must be a resident of, and live in, the state of Ohio at least six (6) months of each year, to be eligible for this Certificate.

Prior to receiving this Certificate, you applied for individual coverage or family coverage. 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.

We will void this Certificate if you, relative to your Application, intentionally misrepresent a material fact or commit fraud.

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 or 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.

Open Enrollment

The open enrollment period begins November 1 and extends through December 15.

During the open enrollment period, the Certificate Holder may request to add new Eligible Dependents or to request a different plan available at that time in the individual market.

Special Enrollment

Outside of open enrollment, the only other time during which you may change plans or add an Eligible Dependent is under a special enrollment period. Special enrollment is triggered by any of the following events:

1. When you or any of your dependents lose other Minimum Essential Coverage. (Loss of Minimum Essential Coverage does not include termination due to non-payment of premium, including COBRA premium, or in the event of rescission.)
2. When you gain or become a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or when you are required to cover a child pursuant to a court order. {(This does not apply to becoming a dependent through a Domestic Partnership. New Domestic Partners may only be added during open enrollment.)}
3. When you lose a dependent or are no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if you or your dependent dies.
4. When you experience an error in enrollment or non-enrollment.
5. When you adequately demonstrate that the plan or issuer substantially violated a material provision of the contract under which you are enrolled.
6. When you become newly eligible or newly ineligible for advance payments of the premium tax credit or experience a change in eligibility for cost-sharing reductions through the Exchange Marketplace (not applicable to Catastrophic Plans).
7. When new coverage becomes available to you as a result of a permanent move.
8. When you or any of your dependents lose eligibility for coverage of pregnancy-related services under Medicaid.
9. When you or any of your dependents lose "medically needy coverage," as described under section 1902 (a)(10)(C) of the Social Security Act (limited to one special enrollment period per calendar year).
10. When you or any of your dependents is enrolled in a non-calendar year group or individual health insurance coverage, even if you or your dependents have the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year.

The request for special enrollment must be received by the plan in which you want to enroll within sixty (60) days of the triggering event.

Your effective date will be determined as defined by federal regulations.

Changes in Coverage

You may change to individual coverage if you no longer have any Eligible Dependents. You must notify us when a Covered Person under your Certificate becomes eligible for Medicare.

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.

Your Identification Card

You will receive identification cards. These cards have the Certificate Holder's name and 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. 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.

Some services may not be covered until an individual has been insured under the plan for a certain period of time, known as a waiting period. When Medical Mutual is replacing a Covered Person's dental plan that was in effect within 60 days preceding the effective date of this coverage, and that dental plan is comparable in benefits to this dental plan, credit will be given for the satisfaction or partial satisfaction of the waiting periods imposed on certain dental services, as described in the Schedule of Benefits.

Refer to the Schedule of Benefits to determine if any services are subject to a waiting period. Waiting periods do not apply to pediatric dental benefits for Covered Persons under age 19.

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 <u>not</u> 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 unrestored permanent molars

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

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
- 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.

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 for Covered Persons under age 19.

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. Orthodontic Treatment, except Medically Necessary Orthodontic Treatment for Covered Persons under age 19.
36. 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.

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, except as provided in 45 CFR 156.1250.

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.

For Medically Necessary Orthodontic Treatment, the proposed Course of Treatment must also include an explanation of how the orthodontic diagnosis relates to the Condition that is being treated, as well as an explanation of how the treatment plan will eliminate the patient's condition.

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 the front of 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 Certificate, 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.

If you are not satisfied with the results and your complaint is regarding a claim, you may continue to pursue the matter through the appeal process.

Benefit Determination for Claims

Urgent Care Claims

An **Urgent Care Claim** is a claim for Dental care or treatment where applying the timeframes for non-urgent care could (a) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (b) in the opinion of a 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*** can be made by (a) an individual acting on behalf of the plan and applying the judgment of a prudent lay person who possesses an average knowledge of medicine or (b) any Dentist or Physician with a knowledge of the claimant's medical Condition who can determine that a claim involves urgent care.

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

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

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

Concurrent Care Claims

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

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

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

Pre-Service Claims

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

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

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

Post-Service Claims

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

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

If an extension is needed because you did not provide all of the necessary information to process your claim, Medical Mutual will notify you, in writing, within the initial 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.

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(s) for the denial;
- reference to the specific plan provision(s) on which the denial is based;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- 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 request;
- if the claim was denied based on Medical Necessity, Experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

Filing an Appeal

If you are not satisfied with a benefit determination or Medical Necessity determination, you may file an appeal.

To submit an appeal electronically, go to Medical Mutual's Web site, www.MedMutual.com, under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card for more information about how to file an appeal. You may also write a letter with the following information: Certificate Holder's full name; Covered Person's full name; identification number; claim number if a claim has been denied; the

reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, dental X-rays or photographs you would like considered in the appeal. Send or fax the letter and records to:

Medical Mutual
Member Appeals Department
P.O. Box 94580
Cleveland, Ohio 44101-4580
Fax: 216-687-7990

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

Mandatory Appeal

Medical Mutual offers all members a mandatory appeal. You must complete this mandatory appeal before any additional action is taken.

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

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law. The internal appeal process is a review of your appeal by an appeals specialist, a Physician consultant and/or other licensed health care professional. The review of the appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations that involve, in whole or in part, issues of Medical Necessity whether services are Experimental and Investigational, or any other medical judgment, are based on the evaluations and opinions of health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior evaluations about your claim and will not be a subordinate of the professional who made the initial evaluation on 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 Provider may request an appeal of a Claim Involving Urgent Care. The appeal does not need to be submitted in writing. 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 review process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

Pre-Service Claim Appeal

- You or your authorized representative may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the

plan Certificate. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of denial.

Post Service Claim Appeal

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

Appeal Denial Notices

All notices of a denial of benefits relative to appeals will include the following:

- the specific reason(s) for the denial;
- reference to the specific plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's 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 claim was denied 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 medical circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

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. 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.

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.

Medical Mutual's rights of subrogation and reimbursement described above shall be modified to comply with the terms of this paragraph in the event that less than the 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 full value of the claim for injury, death, or loss to you resulting from limited liability insurance or any other cause. If less than the full value of the third party action is recovered due the reasons mentioned in the preceding sentence, Medical Mutual's claim shall be reduced in the same proportion as your interest is reduced. Both Medical Mutual and the member 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.

Termination of Coverage

How and When Your Coverage Stops

Your coverage stops:

- When the Certificate Holder becomes ineligible, coverage stops for all Covered Persons.
- When the Certificate Holder does not pay the required premium, coverage stops for all Covered Persons. (See the section entitled "Premiums" for more information.)
- For an Eligible Dependent on the date that person no longer meets the definition of an Eligible Dependent.
- On the day in which 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.
- On the date a Certificate Holder's Domestic Partnership terminates, the Domestic Partner will cease to be eligible for coverage.
- When the Certificate Holder no longer resides, lives or works in the service area (or in an area in which Medical Mutual is licensed to do business).

- Upon 90 days prior notice if cessation of the Group Contract occurs. In the event this happens, you will be offered the option to purchase any other individual coverage currently being offered by Medical Mutual.
- Upon ninety (90) days prior notice if Medical Mutual no longer offers this particular type of health plan coverage in the individual market in the State of Ohio. In that event, Medical Mutual will offer to the Certificate Holder the option to purchase any other individual health insurance coverage currently being offered by Medical Mutual in the individual market in the State of Ohio.
- Upon one-hundred eighty (180) days prior notice to each Covered Person and the Ohio Department of Insurance when Medical Mutual ceases to offer coverage in the individual market in the State of Ohio. In that event, Medical Mutual will comply with all provisions of the Ohio insurance statutes and regulations regarding such event.
- Immediately upon notice if:
  - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
  - a Covered Person materially misrepresents information provided to Medical Mutual or commits fraud or forgery.

Premiums

Grace Period, Cancellation for Non-Payment and Reinstatement

For further periods of coverage, the required premiums must be paid in advance or within the grace period. The grace period is a period of 31 days after the date premium is due. If we do not receive your premium within this grace period, your coverage will end effective on the due date for which the required premium was not received.

Your billing statement from Medical Mutual may be used to provide the Certificate Holder with final notice of cancellation of coverage.

If your coverage is cancelled for non-payment of premium, you may apply for reinstatement of coverage within 60 days after the date notice of cancellation is mailed to you. We will reinstate your coverage, continuous from the date of cancellation, if we determine that your failure to pay the premium was due to extenuating circumstances, such as being incapacitated or incompetent, and you pay all premiums required for reinstatement of coverage.

Change in Premium

We may change premiums for this Certificate by notifying you at least 30 days in advance of the premium change.

Taxes, Fees or Other Charges

Medical Mutual may be subject to taxes, fees or other charges imposed by state or federal government laws or regulations. To the extent permitted by law, Medical Mutual will include such charges, or an estimate of such charges if the actual amount is not known, in your premiums or may show them as a separate line item on your invoice. Medical Mutual reserves the right to adjust your premium or monthly billing during your coverage period, in order to accommodate the payment of such fees, taxes or other charges.

Insufficient Funds

If a check written, or electronic payment made, is returned to Medical Mutual by your financial institution for insufficient funds, Medical Mutual reserves the right to charge you a returned item fee up to the maximum allowed by applicable law.

Changes in Coverage and Obligation to Notify

The benefits provided by this Certificate may be changed or revised at any time. If the provisions of this Certificate are changed or revised, you will be given at least 30 days notice prior to the changes becoming effective. If you continue paying the Premium, it is conclusively determined that you have accepted the changes.

If you are receiving Covered Services under this Certificate at the time your new benefits become effective, we will only provide benefits to the extent that they continue to be Covered Services under the new benefits.

No change in this Certificate will be effective until approved by an authorized officer of Medical Mutual. This approval must be endorsed or attached to the Certificate. No agent or representative of Medical Mutual, other than an officer, may change this Certificate or waive any of its provisions.

Time Limit on Certain Defenses

After coverage under this Certificate has been in force for a period of two (2) years, no misstatements, except fraudulent misstatements, made by the applicant in the application for this coverage shall be used to void this coverage or to deny a claim for loss Incurred or disability (as defined in this Certificate) commencing after the expiration of the two (2) year period.

Change of Beneficiary

The right to change of beneficiary is reserved to the Covered Person, and the consent of the beneficiary(ies) shall not be requisite to surrender or assignment of this Certificate or to any change of beneficiary(ies), or to any other changes in this Certificate.

Cancellation

You may cancel this coverage at any time by giving written notice to Medical Mutual.

This coverage will be cancelled on the date the notice is received or on such later date as specified in the notice.

We will return the unearned portion of any paid premium. This amount will be on a pro-rata basis.

We may not cancel or non-renew this coverage, except as provided in the General Provision describing Grace Period, Cancellation for Non-Payment and Reinstatement or in the General Provision for Termination of Coverage. Cancellation will be without prejudice to any claim for Covered Services Incurred prior to the effective date of cancellation and will not affect claims you Incur before your coverage ends.

Fraud

We may void, terminate, refuse to renew, or modify this coverage, or deny any claim, in whole or in part, for any of the following reasons:

- If you try to obtain benefits to which you know you are not entitled;
- If you help someone try to obtain benefits to which you know that person is not entitled;
- For misrepresentation, fraud or forgery relating to Covered Services;
- For misrepresentation, fraud or forgery relating to the Application;
- For unauthorized use of the identification card issued to you to obtain benefits to which you or another person is not entitled.

Misstatement of Age

If the age of the Certificate Holder has been misstated, we may require you to pay the deficiency in premiums, if any, from the effective date of this Certificate based on the Certificate Holders' correct age.

Notice

Any notice from you concerning this Certificate will be sufficient if sent to:

Medical Mutual of Ohio (Medical Mutual)
100 American Road
Cleveland, Ohio 44144

Any notice to you concerning this Certificate will be sufficient if sent to the Certificate Holder at the last address shown on our records.

Notice of Availability of Language Assistance and Auxiliary Aids and Services

MEDICAL MUTUAL®

English
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-382-5729 (TTY: 711) or speak to your provider.

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-382-5729 (TTY: 711) o hable con su proveedor.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-382-5729 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Italian
ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' 1-800-382-5729 (TTY: 711) o parla con il tuo fornitore.

Russian
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-382-5729 (TTY: 1-711) или обратитесь к своему поставщику услуг.

French
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-382-5729 (TTY: 711) ou parlez à votre fournisseur.

Chinese
注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-982-3117（文本电话：711）或咨询您的服务提供商。

Vietnamese
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-382-5729 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

Arabic
العربيةتنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-382-5729 (TTY: 711)

Korean
주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-382-5729 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Cushite/Oromo
HUBACHIISA: Yoo Afaan Oromoo dubbattu ta'e, tajaajiloonni gargaarsa afaanii bilisaa isiniif ni argamu. Deeggarsi dabalataa fi tajaajilootni mijaa'oo ta'an odeeffannoo bifa dhaqqabamaa ta'een kennuuf gargaaranis kaffaltii malee ni argamu. Gara 1-800-382-5729 (TTY: 711) tti bilbilaa ykn dhiyeessaa keessan haasofsiisaa.

Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-382-5729 (TTY: 711) o makipag-usap sa iyong provider.

Romanian
ATENȚIE: Dacă vorbiți Română, aveți la dispoziție servicii de asistență lingvistică gratuite. De asemenea, sunt disponibile gratuit materiale și servicii auxiliare adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-382-5729 (TTY: 711) sau contactați-vă furnizorul.

Japanese
注:日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-382-5729（TTY:711）までお電話ください。または、ご利用の事業者にご相談ください。

Order Number: Z8188-MCA R8.25
Dept of Ins. Filing Number: Z8188-MCA R10.25

Dutch

LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-800-382-5729 (TTY: 711) of spreek met je provider.

Pennsylvania Dutch

WICHDICH: Wann du Deitsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 1-800-382-5729 (TTY: 711) uff odder schwetz mit dei Provider.

Ukrainian

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-382-5729 (TTY: 711) або зверніться до свого постачальника.

Navajo

BAA'ÁKONÍNÍZIN: Diné bizaad bíyáti' nílt'įį', t'áá jíík'ehgo saad bee áká anilyeedígíí t'áá hóló. T'áá jíík'ehgo áká anilyeedígíí dóó bee haz'ánígíí t'áá hóló, t'áá íiyisí bee t'áá ájík'ehgo. 1-800-382-5729 (TTY: 711) bich'į' hodíilnih dóó provider ni'doolníił.

Notice of Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

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 (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Medical Mutual of Ohio does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Medical Mutual of Ohio:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator at CivilRightsCoordinator@MedMutual.com.

If you believe that Medical Mutual of Ohio has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

100 American Road
Cleveland, OH 44144

Call: 1-800-382-5729 (TTY: 711)
Email: CivilRightsCoordinator@MedMutual.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator (who is also our Section 1557 Coordinator) is available to help you.

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 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

- Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html
- This notice is available at Medical Mutual's website: www.MedMutual.com

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.

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.