IP/MMO/OFF EYEMED VISION ONLY

Group Number

Vision 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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PPO NETWORK VISION CERTIFICATE

This Certificate describes the vision 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 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 does not accept premium payment from any other entity on your behalf, except for Ryan White, Indian tribes and 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 NETWORK VISION SCHEDULE OF BENEFITS

Benefit Period	Rolling 12 months
Dependent Child Age Limit	The end of the month of the 26th birthday.

IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request.

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

The choice of a Provider is solely yours. Providers are designated as PPO Network Providers or Non-PPO Network Providers.

The amount of benefits you receive for Covered Services varies depending upon the status of the Provider. To receive maximum benefits, Covered Services must be provided by a PPO Network Provider. PPO Network Providers are those Providers included in a limited panel of Providers designated by Medical Mutual to perform routine vision services. The status of a Provider can be obtained by calling the Customer Service telephone number listed on the back of your identification card.

When utilizing PPO Network Providers, your benefits are based upon the Vision Allowed Amount.

When utilizing Non-PPO Network Providers, the maximum amount of reimbursement for the Covered Services you receive, after any applicable Copayments, is described below.

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

Type of Service	For Covered Services received from PPO Network Providers, you pay the following, based upon the Vision Allowed Amount		For Covered Services received from Non-PPO Network Providers, you pay the following
	Under age 19	19 and Over	All ages
Vision Examinations Limit of one examination per Benefit Period	$0 Copayment	$15 Copayment	Any amount over $15 per examination
Frames Limit of one Frame per Benefit Period	$0 Copayment for Provider Designated Frames (1)	$15 Copayment and any amount over $130 per Frame	Any amount over $30 per Frame
Lenses Limit of one pair per Benefit Period	$0 Copayment for Single Vision, Bifocal, Trifocal, or Lenticular Lenses	$15 Copayment for Single Vision, Bifocal, Trifocal, or Lenticular Lenses	Single Vision Any amount over $10 per pair Bifocal Any amount over $20 per pair Trifocal Any amount over $30 per pair Lenticular Any amount over $40 per pair
Lens Options • Scratch-resistant Coating • Ultraviolet Coating	$0 Copayment	$15 Copayment	Any amount over $10
Contact Lenses (2)	Medically Necessary: • 0% Cosmetic/Disposable • 0% for Provider Designated Contact Lenses (1)	Medically Necessary: • 0% Cosmetic/Disposable • $15 Copayment and any amount over $130	Medically Necessary: • Any amount over $75 per pair Cosmetic/Disposable • Any amount over $40 per pair
Standard Contact Lens Fit and Follow-up Limit of two visits per Benefit Period	$0 Copayment	$0 Copayment	Any amount over $10
Premium Contact Lens Fit and Follow-up Limit of two visits per Benefit Period	$0 Copayment	Any amount over $55	Any amount over $10

Notes:

1. Designated available Frame at Provider location.
2. Contact Lens limits:
   - **Extended Wear Disposables (Single-vision spherical or toric)**

     Up to a six-month supply of monthly wear or two-week wear disposable Contact Lenses

- **Daily Wear Disposables (Single-vision spherical or toric)**
  Up to a three-month supply of daily disposable Contact Lenses
- **Conventional**
  One pair of Contact Lenses
- **Medically Necessary**
  One pair of Contact Lenses

HOW TO USE YOUR CERTIFICATE

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

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

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 **Vision 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 Vision 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 when your premium is due.

DEFINITIONS

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

Benefit Period - the period of time specified in the Schedule of Benefits during which Covered Services are rendered and benefit 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 a Vision 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.

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

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

Contact Lenses - corrective Lenses, ground or molded, as prescribed by a Physician or Optometrist to be directly fitted to your eye.

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.

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

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

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

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

Excess Charges - the difference between the Billed Charges and the Vision Allowed Amount.

Experimental or Investigational - a procedure or lens that is not used universally or accepted by the vision care profession, as determined by Medical Mutual.

Frame - standard eyeglasses excluding the Lenses.

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

Group - 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 - rendered to you by a 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.

Lenses - glass or plastic single vision, bifocal, trifocal or lenticular corrective materials which are ground as prescribed by a licensed Provider and include fashion and gradient tinting, ultraviolet protective coating, oversized and glass-gray #3 prescription sunglass lenses.

Medically Necessary (or Medical 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 medical practice and not Experimental or Investigational;
- not primarily for your convenience or the convenience of a Provider; and
- the most appropriate supply or level of service which can be safely provided to you.

Contact Lenses are considered Medically Necessary when:

- necessary following cataract surgery;
- visual acuity cannot be corrected to 20/70 in either eye with other Lenses; or
- required for the treatment of anisometropia or keratoconus.

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

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

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

Optician - a person lawfully engaged in dispensing Lenses prescribed by a Physician or Optometrist.

Optometrist - a person licensed to practice optometry.

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

- Optometrist; and
- Optician.

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

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

Provider - Physician or Other Professional Provider.

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.

Vision Allowed Amount - the amount specified as payable for Covered Services in the Schedule of Benefits, or for Covered Services not specified in the Schedule of Benefits, the maximum amount payable, as determined by Medical Mutual.

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 misrepresented 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, 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.

Effective Date

Coverage starts at 12:01 a.m. on the effective date. The effective date is determined by Medical Mutual. No benefits will be provided for services, supplies or charges Incurred before your effective date.

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.If a parent of an Eligible Dependent child is required by a court or administrative order to provide health insurance coverage for such child, and if the parent is eligible for family health insurance coverage provided by Medical Mutual, the Eligible Dependent child may be enrolled under his or her parent's family coverage without regard to enrollment period restrictions.

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.

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.

VISION BENEFITS

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

Please refer to the Schedule of Benefits for the specific amount of benefits payable for Covered Services.

The following are Covered Services:

Vision Examinations (Routine and Medically Necessary) - Medical Mutual will cover comprehensive examination components as follows:

- a case history
- general patient observation
- clinical and diagnostic testing and evaluation
    - inspection of conjunctivae and sclera
    - examination of orbits
    - test visual acuity
    - gross visual field testing
    - ocular motility
    - binocular testing
    - examination of irises, cornea(s), lenses, and anterior chambers
    - examination of pupils
    - measurement of intraocular pressure (tonometry)
    - ophthalmoscopic examinations
- determination of refract status
- color vision testing
- stereopsis testing
- case presentation including summary findings and recommendations including prescribing Lenses

Prescribed Lenses and Frames - Medical Mutual will cover the following services only when performed to obtain prescribed Lenses and Frames:

- facial measurements and determination of interpupillary distance
- assistance in choosing Frames
- verification of Lenses as prescribed
- after-care for a reasonable period of time for fitting and adjustment.

Prescribed Contact Lens Evaluations and Follow-up - Medical Mutual will cover contact lens compatibility tests, diagnostic evaluations, and diagnostic lens analysis to determine a patient's suitability for Contact Lenses or a change in Contact Lenses. Appropriate follow-up care is also covered.

Low Vision Services (for Covered Persons under age 19 only) - Medical Mutual will cover the evaluation of a Covered Person's low vision, as well as training and instruction to maximize the remaining usable vision. "Low vision" means a significant loss of vision but not total blindness. Covered low vision services include: one comprehensive low vision evaluation every five years; low vision optical devices, such as high-powered spectacles, magnifiers and telescopes; and follow-up care, limited to four visits in any five-year period.

EXCLUSIONS

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

1. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
2. Not performed within the scope of the Provider's license.
3. For Experimental or Investigational equipment, drugs, devices, services, supplies, tests, medical treatments or procedures.
4. 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.
5. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
6. Received in a military facility for a military service related Condition.
7. Received from a vision clinic or similar vision facility maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
8. For which you have no legal obligation to pay in the absence of this or like coverage.
9. Received from a member of your Immediate Family.
10. For a Condition that occurs as a result of any act of war, declared or undeclared.
11. Which are rendered prior to your effective date.
12. Incurred or received after you stop being a Covered Person.
13. For medical or surgical treatment of the eye, eyes or supporting structures.
14. For diagnostic services, drugs or medications not part of a vision examination.
15. That Medical Mutual determines are special or unusual; such as orthoptics, vision training, Aniseikonic Lenses and low vision aids, unless otherwise specified.
16. For Lenses which are not prescribed.
17. For safety glass and safety goggles.
18. For tints other than Number One or Two.
19. For tints with photosensitive properties for Covered Persons over age 19.
20. For plano Lenses (Lenses with refractive correction of less than ± .50 diopter).
21. For two pair of glasses instead of bifocals.
22. For the replacement of Lenses, Frames or Contact Lenses that are lost or damaged, other than at the normal intervals, when plan benefits are otherwise available.
23. For spectacle lens treatments or "add-ons", except for tints Number One or Two.
24. For refitting of Contact Lenses after the initial (90-day) fitting period.
25. For Contact Lens modification, polishing or cleaning.
26. For any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).
27. For any oral, written or electronic communications or consultations, by a Provider with a Covered Person or another Provider that do not involve in-person contact with the Covered Person.
28. For fraudulent or misrepresented claims.
29. 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. Many Providers will submit a claim for you; if you submit it yourself, you should use a claim form. In most cases, you can obtain a claim form from your Group or Provider. If your Provider does not have a claim form, Medical Mutual or the PPO Network Provider will send you one. Call or notify Medical Mutual or the PPO Network Provider, in writing, within 20 days after receiving your first Covered Service or as soon as reasonably possible, and you will be sent a claim form. You may also print a claim form by going to medmutual.com/member.

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

Proof of Loss

Proof of loss is a claim for payment of vision services which has been submitted for processing with sufficient documentation to determine whether Covered Services have been provided to you. A completed claim with the correct information is required for processing.

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 after services have been received.

How Claims are Paid

Your Financial Responsibilities

For Covered Services, Medical Mutual will calculate its payment based upon the Vision Allowed Amount.

You are responsible for paying Non-Covered Charges and Billed Charges for all services and supplies after benefit maximums have been reached. You may also be responsible for Excess Charges if your Provider does not accept the Vision Allowed Amount as payment in full. PPO Network Providers have agreed to not bill for any amount of Covered Charges above the Allowed Amount, except for services and supplies for which Medical Mutual has no financial responsibility due to a benefit maximum.

Your financial responsibilities include any Coinsurance and/or Copayments.

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

Provider Status and Direction of Payment

Medical Mutual has agreed to make payment directly to PPO Network Providers.

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

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

You authorize Medical Mutual to make payments directly to Providers who have performed Covered Services for you. Medical Mutual also reserves the right to make payment directly to you. When this occurs, you must pay the Provider and 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.

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 Providers as PPO Network Providers or Non-PPO Network Providers is not a statement about their abilities.

Explanation of Benefits

After your claim is processed, an Explanation of Benefits (EOB) is mailed to you. 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.

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

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

Benefit Determination for Claims

Claims Involving Urgent Care

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

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

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

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

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

Concurrent Care Claims

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

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

Pre-Service Claims

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

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

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

Post-Service Claims

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

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

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

Adverse Benefit Determination Notices

You will receive notice of a benefit determination, orally as allowed, or in writing. All notices of an adverse benefit determination will include the following:

- the specific reason(s) for the adverse benefit determination;
- reference to the specific plan provision(s) on which the adverse benefit determination is based;
- sufficient information to identify the claim or health care service involved, including the date of services, the health care provider, and the claim amount, if applicable;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of appeal procedures and applicable timeframes, including the expedited appeal process, if applicable;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the adverse benefit determination was based on Medical Necessity, Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

Filing an Appeal

How to File an Appeal

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

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

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

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

Mandatory Internal Appeal

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

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

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

All determinations that involve, in whole or in part, issues of Medical Necessity, whether services are Experimental and Investigational, or any other medical judgment, are based on the evaluations and opinions of health care

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

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

The appeal procedures are as follows:

Appeal of a Claim Involving Urgent Care

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

Pre-Service Claim Appeal

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

Post Service Claim Appeal

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

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

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

Claim Review

Consent to Release Medical Information - Denial of Coverage

You consent to the release of medical information to Medical Mutual and its vision PPO Network Providers when you sign an Application.

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

Right to Review Claims

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

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, Certificate Holder, 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, Certificate Holder, 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 or Domestic Partner of the **Custodial parent**;
                - The **Plan** covering the **non-custodial parent**; and then
                - The **Plan** covering the spouse or Domestic Partner of the **non-custodial parent**.
        3. For a dependent child covered under more than one **Plan** of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.
    c. Active employee or retired or laid-off employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.
    d. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

e. Longer or shorter length of coverage. The **Plan** that covered the person as an employee, member, Certificate Holder, 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.

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).
- By cessation of the Group Contract.
- 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. During the grace period, this Certificate will stay in force; however, the payment of any claims Incurred during the grace period may be suspended by Medical Mutual until all required premiums are received by Medical Mutual.

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.

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