SG/MMO/OFF SILVER HSA 5000

Group Number

PPO Network Comprehensive Major Medical Health Care 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.

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL HEALTH CARE CERTIFICATE

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

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

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

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

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

NOTICE:

IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Medical Mutual of Ohio (Medical Mutual)

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Medical Mutual.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

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

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

BENEFIT PERIOD AND DEPENDENT AGE LIMIT	
Benefit Period	Calendar year
Dependent Child Age Limit	The end of the month of the 26th birthday

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL BENEFIT	
Deductible per Benefit Period for PPO Network Providers If you have single coverage: If you have family coverage:	 $5,000 $10,000
Deductible per Benefit Period for Contracting, Non-PPO Network Providers and Non-Contracting Providers If you have single coverage: If you have family coverage:	 $10,000 $20,000
Out-of-Pocket Maximum per Benefit Period for PPO Network Providers (Includes Deductibles, Copayments, and Coinsurance) If you have single coverage: If you have family coverage:	 $5,000 $10,000
Out-of-Pocket Maximum per Benefit Period for Contracting, Non-PPO Network Providers and Non-Contracting Providers (Includes Deductibles, Copayments, and Coinsurance) If you have single coverage: If you have family coverage:	 $20,000 $40,000
Penalty for failure to obtain Precertification/Prior Approval of the Organ Transplant when utilizing a Non-Contracting Provider	$5,000 (Not applied to Out-of-Pocket Maximum)
Penalty when utilizing a Non-Designated Transplant Center for an Organ Transplant	$10,000 (Not applied to Out-of-Pocket Maximum)
Deductible and Out-of-Pocket Maximum Processing	Embedded "Embedded processing" - A family plan with two kinds of Deductibles and Out-of-Pocket Maximums: one for an individual family member and one for the whole family. With family coverage, each Covered Person's Out-of-Pocket Maximum will not exceed the Out-of-Pocket Maximum for single coverage shown on the Schedule of Benefits.

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

Any Excess Charges you pay for claims will not accumulate toward the Out-of-Pocket Maximum.

The Deductible and Out-of-Pocket Maximum that applies to PPO Network Providers accumulates separately from the Deductible and Out-of-Pocket Maximum that applies to Contracting, Non-PPO Network Providers and Non-Contracting Providers.

COMPREHENSIVE MAJOR MEDICAL BENEFIT MAXIMUMS PER COVERED PERSON	
(per Benefit Period unless otherwise shown)	
Chiropractic/Spinal Manipulation Visits	12 visits
Habilitative Services, including, but not limited to, services for Autism Spectrum Disorder for children under age 21: • Clinical Therapeutic Intervention • Occupational Therapy • Speech and Language Therapy	 20 hours per week 20 visits 20 visits
Home Health Care Services	100 visits
Mastectomy Bras	Four bras
Outpatient Cardiac Rehabilitation Services	36 visits
Outpatient Occupational and Physical Therapy Services	40 visits (combined)
Outpatient Pulmonary Therapy Services	20 visits
Outpatient Speech Therapy Services	20 visits
Physical Medicine and Rehabilitation	60 days
Private Duty Nursing Services	90 days
Routine Mammogram Services	One mammogram
Routine Pap Tests	One test
Skilled Nursing Facility Services	90 days
Wigs following cancer treatment	One wig

MAXIMUM BENEFIT PAYABLE FOR TRANSPLANT RELATED SERVICES (travel related expenses, donor search)	
For travel, meals, lodging and transportation related to the Covered Person's transplant	Up to $10,000 per transplant
For unrelated donor search for bone marrow/stem cell transplants related to the Covered Person's transplant	Up to $30,000 per transplant

COINSURANCE AND COPAYMENTS FOR COVERED CHARGES		
TYPE OF SERVICE (Institutional and Professional)	**For PPO Network Providers, you pay the following portion, based on the Allowed Amount.**	**For Contracting, Non-PPO Network Providers, you pay the following portion, based on the Allowed Amount. For Non-Contracting Providers, you pay the following portion, based on the Non-Contracting Amount and may be balance billed. (1)(2)**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
EMERGENCY ROOM SERVICES		
The Institutional charge for use of the Emergency Room in an Emergency	0%	
All other related Institutional charges and Emergency Room Physician's charges in an Emergency	0%	
INPATIENT SERVICES		
Semi-Private Room and Board	0%	50%
Physical Medicine and Rehabilitation	0%	50%
Maternity	0%	50%
Skilled Nursing Facility	0%	50%
MENTAL HEALTH CARE, DRUG ABUSE AND ALCOHOLISM SERVICES		
Mental Health Care, Drug Abuse and Alcoholism Services	Any applicable Deductible, Out-of-Pocket Maximum or Copayment corresponds to the type of service received and is payable on the same basis as any other illness (e.g., emergency room visits for a Mental Illness will be paid according to the Emergency Services section above).	
OUTPATIENT REHABILITATIVE AND HABILITATIVE SERVICES		
Cardiac Rehabilitation Services	0%	50%
Chiropractic Services	0%	50%
Occupational and Physical Therapy Services	0%	50%
Respiratory/Pulmonary Therapy Services	0%	50%
Speech Therapy Services	0%	50%
PHYSICIAN/OFFICE SERVICES (includes Mental Health and Substance Abuse disorders)		
Medically Necessary Office Visits (3)	0%	50%
Medically Necessary Office Visits in a Specialist's Office	0%	50%
Urgent Care Office Visits	0%	50%
ROUTINE AND PREVENTIVE SERVICES		
Preventive Service benefits are provided in accordance with state and federal law. Refer to the "Routine and Preventive Services" health care benefit for details. (4)	0%, not subject to the Deductible	50%

COINSURANCE AND COPAYMENTS FOR COVERED CHARGES		
TYPE OF SERVICE (Institutional and Professional)	**For PPO Network Providers, you pay the following portion, based on the Allowed Amount.**	**For Contracting, Non-PPO Network Providers, you pay the following portion, based on the Allowed Amount. For Non-Contracting Providers, you pay the following portion, based on the Non-Contracting Amount and may be balance billed. (1)(2)**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
Routine Laboratory, X-ray and Medical Testing Services	0%	50%
Routine Prostate Specific Antigen (PSA) Tests	0%	50%
SURGICAL SERVICES		
Inpatient and Outpatient Surgery	0%	50%
Medically Necessary Endoscopic Procedures (i.e, Colonoscopy, Sigmoidoscopy, etc.)	0%	50%
OTHER SERVICES		
Allergy Tests and Treatment	0%	50%
Ambulance Services	0%	50%
Home Health Care Services	0%	50%
Hospice Services	0%	50%
Medical Supplies and Durable Medical Equipment (DME)	0%	50%
Organ Transplant Services	0%	50%
Outpatient Medically Necessary Laboratory, X-ray and Medical Testing Services	0%	50%
All Other Covered Services	0%	50%

Comprehensive Major Medical Notes

1. The Coinsurance percentage will be the same for Non-Contracting Providers as Non-PPO Network Providers, but for Non-Contracting Providers, you may still be subject to balance billing and/or Excess Charges. Payments to Contracting Non-PPO Network Providers are based on the Allowed Amount. Payments to Non-Contracting Providers are based on the Non-Contracting Amount.
2. In circumstances where Medicare is the primary payer for a Covered Person, the out-of-network reductions in the benefits set forth above do not apply.
3. Includes Office Visits to a Psychiatrist or Psychologist, Licensed Independent Social Worker, Licensed Professional Clinical Counselor, and Licensed Marriage-Family Therapist.
4. Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

PRESCRIPTION DRUG BENEFIT

This plan uses a Prescription Drug Formulary. Prescription Drugs not listed on the Formulary are generally not covered. See the Prescription Drug Benefit description for more information.

Prescription Drug Covered Services are subject to any Comprehensive Major Medical Benefit Period Deductible and Out-of-Pocket Maximum shown in the Comprehensive Major Medical Schedule of Benefits.

Specialty Prescription Drugs are covered under this benefit when obtained through Medical Mutual's Contracting Specialty Pharmacy(ies) and are limited to a maximum of a thirty (30) day supply. Specialty Prescription Drugs require prior approval from Medical Mutual.

RETAIL PHARMACY BENEFIT - UP TO A 30 DAY SUPPLY [(1)]	
TYPE OF SERVICE	**For Covered Services, you pay the following portion, based on the Allowed Amount**
Generic Prescription Drugs	0%
Preferred Brand Name Prescription Drugs for which no Generic Prescription Drug is available or manufactured	0%
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	0%
Non-Preferred Brand Name Prescription Drugs for which no Generic Prescription Drug is available or manufactured	0%
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	0%
Prescribed Generic Prescription Drug Contraceptives or Brand Name Prescription Drug Contraceptives when an equivalent Generic Prescription Drug Contraceptive is not available	0%, not subject to the Deductible
Preventive Prescription Drugs and Vaccines in accordance with state and federal law.	0%, not subject to the Deductible
Prescription Drugs received from non-Network Pharmacies	You pay the entire amount at the Pharmacy and file a claim form with Medical Mutual. Medical Mutual will reimburse you based on the Allowed Amount of the Prescription Drug, minus the Prescription Drug Copayment or Coinsurance, as indicated. You may be responsible for any amount in excess of the Prescription Drug Covered Charges. If the Prescription Drug is not available from a Network Pharmacy, you will not be subject to this reduced reimbursement.

CONTRACTING HOME DELIVERY PHARMACY BENEFIT - 90 DAYS SUPPLY [1]	
TYPE OF SERVICE	**For Covered Services received from a CONTRACTING Home Delivery Pharmacy, you pay the following portion, based on the Allowed Amount**
Generic Prescription Drugs	0%
Preferred Brand Name Prescription Drugs for which no Generic Prescription Drug is available or manufactured	0%
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	0%
Non-Preferred Brand Name Prescription Drugs for which no Generic Prescription Drug is available or manufactured	0%
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	0%
Prescribed Generic Prescription Drug Contraceptives or Brand Name Prescription Drug Contraceptives when an equivalent Generic Prescription Drug Contraceptive is not available	0%, not subject to the Deductible
Preventive Prescription Drugs and Vaccines in accordance with state and federal law.	0%, not subject to the Deductible

Coverage is provided for Contracting Home Delivery Pharmacies only. Services received from any Non-Contracting Home Delivery Pharmacy are excluded.

Prescription Drug Notes:

1. This plan does not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications.

PPO PEDIATRIC VISION BENEFIT

Subject to all other terms and conditions of this Certificate, this benefit will terminate at the end of the month following the Covered Person's nineteenth (19th) birthday.

To receive maximum benefits, Covered Services must be provided by a PPO Network Provider. When Covered Services are provided by Non-PPO Network Providers, your benefits will be lower.

BENEFIT MAXIMUMS PER COVERED PERSON	
Frames	One Frame per Benefit Period
Lenses [(1)]	One pair per Benefit Period
Contact Lenses [(1)]	One pair per Benefit Period

COINSURANCE AND COPAYMENTS		
Type of Service	**You Pay the Following Portion Based on the Allowed Amount For PPO Network Providers**	**You Pay the Following Portion Based on the Non-Contracting Amount For Non-PPO Network Providers**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
Vision Spectacle or Contact Lens Examinations	0%, not subject to the Deductible	50%
Lenses [(2)]	0%	50%
Frames	0%	50%
Contact Lenses	0%	50%
Disposable Contact Lenses	0%	50%
Medically Necessary Contact Lenses	0%	50%
Low Vision Services	0%	50%

Vision Notes

1. Benefits available for Lenses may be used for Contact Lenses in lieu of Lenses.
2. Optional Lenses and Treatments include:
    - Ultraviolet protective coating
    - Polycarbonate lenses
    - Blended segment lenses
    - Intermediate vision lenses
    - Standard and premium progressive lenses
    - Photochromic glass lenses
    - Plastic photosensitive lenses
    - Polarized lenses
    - Standard, premium and ultra anti-reflective (AR) coating
    - Hi-Index lenses

HOW TO USE YOUR CERTIFICATE

This Certificate describes your health care benefits. Please read it carefully.

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

The **Definitions** section will help you understand unfamiliar words and phrases. If a word or phrase starts with a capital letter, it is either a title or it has a special meaning. If the word or phrase has a special meaning, it will be defined in this section or where used in the 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 **Health Care Benefits** section explains your benefits and some of the limitations on the Covered Services available to you.

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

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

DEFINITIONS

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

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

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

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

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

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 Provider for services and supplies provided to a Covered Person.

Biosimilar Prescription Drug - a Prescription Drug that:

- is highly similar to a Food and Drug Administration (FDA) approved Specialty Prescription Drug but may have minor differences that are not medically meaningful;
- may or may not be interchangeable with the Specialty Prescription Drug to which it is comparable; and
- may sometimes be considered a Generic equivalent of the Specialty Prescription Drug to which it is comparable.

Brand Name Prescription Drug - a Prescription Drug that is included in Medical Mutual's Formulary and is classified as "Brand Name."

Certificate - this document.

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

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

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

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.

Contraceptives - FDA-approved methods of birth control, including, but not limited to, barrier methods, hormonal methods and implanted devices.

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

Contracting - the status of a Provider:

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

Contracting Home Delivery Pharmacy - a Pharmacy which dispenses Prescription Drugs through the mail and which has a contractual obligation with Medical Mutual to provide services.

Contracting Specialty Pharmacy - a Pharmacy which dispenses Specialty Prescription Drugs and which has a contractual obligation with Medical Mutual to provide services.

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

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

Covered Person - the 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 this Certificate for which Medical Mutual will provide benefits, as listed in the Schedule of Benefits.

Custodial Care - care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting their activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes but is not limited to:

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

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

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

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

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.

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

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

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

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

Essential Health Benefits - benefits defined under federal law (PPACA) as including benefits in at least the following categories; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

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

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

Reliable evidence may consist of any one or more of the following:

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

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

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

Formulary - a list of Generic Prescription Drugs, Brand Name Prescription Drugs and over-the-counter drugs that are covered under this plan.

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.

Generic Prescription Drug - a Prescription Drug that is produced by more than one manufacturer. It is chemically the same as and usually costs less than the Brand Name Prescription Drug for which it is being substituted and will produce comparable effective clinical results.

Home Delivery Prescription Drug - a Prescription Drug which can be provided by a Home Delivery Pharmacy.

Hospital - an accredited Institution that meets the specifications set forth in the appropriate Chapter of the Ohio Revised Code and any other regional, state or federal licensing requirements, except for the requirement that such Institution be operated within the state of Ohio.

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

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

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

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

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.

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

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

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

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

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

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

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

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

The Negotiated Amount for Providers does not include adjustments and/or settlement due to prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations, performance withhold adjustments or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim. In addition, the Negotiated Amount for Prescription Drugs does not include Pharmacy rebates that Medical Mutual may receive from its Pharmacy benefit manager or payments resulting from discount guarantees.

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

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

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

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

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

Non-PPO Network Provider - a Contracting Provider that does not meet the definition of a PPO Network Provider.

Non-Preferred Brand Name Prescription Drug - a Brand Name Prescription Drug that is included in Medical Mutual's Formulary and is classified as "Non-Preferred."

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

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

- **Alcoholism Treatment Facility -** a facility that mainly provides detoxification and/or rehabilitation treatment for Alcoholism.
- **Ambulatory Surgical Facility -** a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a Physician and also includes nursing services.
- **Day/Night Psychiatric Facility -** a facility that is primarily engaged in providing diagnostic services and therapeutic services for the Outpatient treatment of Mental Illness. These services are provided through either a day or night treatment program.
- **Dialysis Facility -** a facility that mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- **Drug Abuse Treatment Facility -** a facility that mainly provides detoxification and/or rehabilitation treatment for Drug Abuse.
- **Home Health Care Agency -** a facility that meets the specifications set forth in the appropriate Chapter of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio and which provides nursing and other services as specified in the Home Health Care Services section of this Certificate. A Home Health Care Agency is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Hospice Facility -** a facility that provides supportive care for patients with a reduced life expectancy due to advanced illness as specified in the Hospice Services section of this Certificate.
- **Psychiatric Facility -** a facility that is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.
- **Psychiatric Hospital -** a facility that is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Inpatient basis. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must be provided under the supervision of a registered nurse.
- **Skilled Nursing Facility -** a facility that primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a Physician.

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

- advanced nurse practitioner (A.N.P.);
- ambulance services;
- certified dietician;
- certified nurse-midwife;
- certified nurse practitioner;
- clinical nurse specialist;
- dentist;
- doctor of chiropractic medicine;
- durable medical equipment or prosthetic appliance vendor;
- laboratory (must be Medicare Approved);
- licensed independent social workers (L.I.S.W.);
- licensed practical nurse (L.P.N.);
- licensed professional clinical counselor;
- licensed professional counselor;

- licensed vocational nurse (L.V.N.);
- mechanotherapist (licensed or certified prior to November 3, 1975);
- occupational therapist;
- ophthalmologist;
- optometrist;
- osteopath;
- Pharmacy;
- physical therapist;
- physician assistant;
- podiatrist;
- Psychologist;
- registered nurse (R.N.);
- registered nurse anesthetist; and
- Urgent Care Provider.

Covered Services provided by Providers not listed here will also be considered for reimbursement if the Provider is acting within the scope of his or her license or certification under state law.

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.

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

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

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

PPACA - Patient Protection and Affordable Care Act

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

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

Preauthorization - A decision by Medical Mutual that a health care service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. This is also referred to as "precertification" or "prior approval". Medical Mutual requires Preauthorization before you are admitted as an Inpatient in a Hospital or before you receive certain services, except for an Emergency Medical Condition. Payment of benefits is still subject to all other terms and conditions of the plan.

Preferred Brand Name Prescription Drug - A Brand Name Prescription Drug that is included in Medical Mutual's Formulary and is classified as "Preferred."

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

Prescription Drug Negotiated Amount - the amount the Pharmacy has agreed to accept as payment in full for Covered Services.

The Prescription Drug Negotiated Amount for Prescription Drugs does not include any share of Formulary reimbursement savings (rebates), volume based credits or refunds or discount guarantees.

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

Prescription Drug Order - the request for medication by a Physician or Other Professional Provider who is licensed by his or her state to make such a request in the ordinary course of Professional practice.

Professional - a Physician or Other Professional Provider.

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

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

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

Residential Treatment Facility - a facility that meets all of the following:

- An accredited facility that provides care on a 24 hour a day, 7 days a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders who do not require care in an acute or more intensive medical setting.
- The facility must provide room and board as well as providing an individual treatment plan for the chemical, psychological and social needs of each of its residents.
- The facility must meet all regional, state and federal licensing requirements.
- The residential care treatment program is supervised by a professional staff of qualified Physician(s), licensed nurses, counselors and social workers.

Rider - a document that amends or supplements your coverage.

Routine Services - Services not considered Medically Necessary.

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

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

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

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

Specialty Prescription Drugs - A Prescription Drug that:

- is approved only to treat limited patient populations, indications or Conditions; and
- is normally, but not always, injected, infused or requires close monitoring by a Physician or clinically trained individual; and
- meets one of the following:
  - the FDA has restricted distribution of the drug to certain facilities or Providers; or
  - requires special handling, Provider coordination or patient education that cannot be met by a retail Pharmacy.

Stabilize - with respect to an Emergency Medical Condition, to provide such medical treatment of the Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the Condition is likely to result from or occur during the transfer of the individual from a facility.

Substance Abuse - Alcoholism and/or Drug Abuse.

Surgery -

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

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

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

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

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

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

ELIGIBILITY

Applying for Coverage

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

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

Eligible Employees

An Eligible Employee is an employee who:

- works an average of 30 or more hours per week
- meets the eligibility criteria stated in the Group Contract and established by the Group
- has satisfied any applicable waiting period, which will not exceed 90 days

No person who is eligible to enroll will be denied enrollment based upon health status, health care needs, genetic information, previous medical information, disability or age.

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, spouse's or Domestic Partner's:
  - natural children;
  - stepchildren, provided the natural parent remains married to the Certificate Holder and resides in the household;
  - 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.

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

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

Qualified Medical Child Support Order

In general, a Qualified Medical Child Support Order (QMCSO) is a court order that requires a Certificate Holder to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or paternity dispute. A QMCSO may not require the plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. This plan provides benefits according to the requirements of any QMCSO as defined by ERISA section 609(a). The Group will promptly notify affected Certificate Holders and alternate recipients if a QMCSO is received. The Group will notify these individuals of its procedures for determining whether medical child support orders are qualified; within a reasonable time after receipt of such order, the Group will determine whether the order is qualified and notify each affected Certificate Holder and alternate recipient of its determination. A copy of the Group's QMCSO procedures is also available upon request from the Group, without charge.

Once the dependent child is enrolled as an alternate recipient under a QMCSO, the child's appointed guardian will receive a copy of all pertinent information provided to the Certificate Holder. In addition, should the Certificate Holder lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

Effective Date

Coverage starts at 12:01 a.m. on the effective date. No benefits will be provided for services, supplies or charges Incurred before your effective date. Your employer will have rules regarding when your coverage becomes effective, including any applicable waiting periods. Your employer will notify you of the date your group coverage will become effective at the time you enroll for coverage.

Changes in Coverage

If you have individual coverage, you may change to family coverage if you marry or declare a Domestic Partnership or you or your spouse or Domestic Partner acquire an Eligible Dependent. You must notify your Group benefits administrator who must then notify Medical Mutual of the change.

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

A newborn child will be covered for 31 days from the date of birth without premium payment. If additional premium is required to provide coverage beyond 31 days from the newborn's date of birth, the request to cover the newborn must be received by Medical Mutual within 31 days from the date of birth, and payment of the required premium must be paid when due. Adopted children and children placed for adoption, regardless of whether the adoption has become final, will be covered on the same basis as any other dependent children. Coverage will continue for a child placed for adoption, unless the placement is disrupted prior to legal adoption, and the child is removed from placement.

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

Special Enrollment

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

1. In order to qualify for special enrollment rights because of loss of coverage, you or your Eligible Dependent must have had other group health plan coverage at the time coverage under this Certificate was previously offered. You or your Eligible Dependent must have also stated, in writing, at that time that coverage was declined because

of the other coverage, but only if Medical Mutual required such a statement at the time coverage was declined, and you were notified of this requirement and the consequences of declining coverage at that time.

2. If coverage was non-COBRA, loss of eligibility or the Group's contributions must end. A loss of eligibility for special enrollment includes:
   a. Loss of eligibility for coverage as a result of divorce, legal separation or termination of Domestic Partnership.
   b. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Certificate)
   c. Death of an Eligible Employee
   d. Termination of employment
   e. Reduction in the number of hours of employment that results in a loss of eligibility for plan participation (including a strike, layoff or lock-out)
   f. Loss of coverage that was one of multiple health insurance plans offered by an employer, and the Eligible Employee elects a different plan during an open enrollment period
   g. An individual no longer resides, lives, or works in an HMO Service Area (whether or not within the choice of the individual), and no other benefit package is available to the individual through the other employer
   h. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual
   i. A situation in which an individual incurs a claim that would meet or exceed a medical plan lifetime limit on all benefits (additional requirements apply)
   j. Termination of an employee's or dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)
   k. The employee or dependent is determined to be eligible for premium assistance in the Group's plan under a Medicaid or CHIP plan
3. If you or your Eligible Dependent has COBRA coverage, the coverage must be exhausted in order to trigger a special enrollment right. Generally, this means the entire 18, 29 or 36-month COBRA period must be completed in order to trigger a special enrollment for loss of other coverage.
4. Enrollment must be supported by written documentation of the termination of the other coverage with the effective date of said termination stated therein. With the exception of items "j" (termination of Medicaid or CHIP coverage) and "k" (eligibility for premium assistance) above, notice of intent to enroll must be provided to Medical Mutual by the Group no later than thirty-one (31) days following the triggering event with coverage to become effective on the date the other coverage terminated. For items "j" and "k" above, notice of intent to enroll must be provided to Medical Mutual by the Group within sixty (60) days following the triggering event, with coverage to become effective on the date of the qualifying event.

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

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

Your Identification Card

You will receive identification cards. These cards have the Certificate Holder's name, subscriber number and group number on them. The identification card should be presented when receiving Covered Services under this coverage because it contains information you or your Provider will need when submitting a claim or making an inquiry. Your receipt or possession of an identification card does not mean that you are automatically entitled to benefits.

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

HEALTH CARE BENEFITS

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

Please refer to the Prior Approval of Benefits Received from Non-PPO Network or Non-Contracting Providers in the How Claims Are Paid section of the General Provisions for information regarding services received from Providers who are not in the PPO Network.

Women's Health and Cancer Rights Act Notice

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

Allergy Tests and Treatments

Allergy tests and treatment that are performed and related to a specific diagnosis are Covered Services. Desensitization treatments are also covered.

Ambulance Services

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

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

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

Transportation for Emergency Medical Conditions will also be covered when provided by a professional ambulance service for other than local ground transportation such as air and water transportation, only when special treatment is required and the transportation is to the nearest Hospital qualified to provide the special treatment.

Covered ambulance services include treatment of a sickness or injury by medical Professionals from an ambulance service when you are not transported if Medically Necessary.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and the Covered Person is not in a position to refuse, or
- When a Covered Person is required by us to move from a Non-PPO Network Provider to a PPO Network Provider.

Non-Covered services for ambulance include, but are not limited to, trips to a Physician's office, clinic, a morgue or a funeral home. Transportation services provided by an ambulette or a wheelchair van are also not Covered Services.

Case Management

Case management is an economical, common-sense approach to managing health care benefits. Medical Mutual's case management staff evaluates opportunities to cover cost-effective alternatives to the patient's current health care needs. Case management has proven to be very effective with catastrophic cases, long-term care, and psychiatric and substance abuse treatment. In such instances, benefits not expressly covered in this Certificate may be approved. All case management programs are voluntary for the patient.

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

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

Clinical Trial Programs

Benefits are provided for Routine Patient Costs administered to a Covered Person participating in any stage of an Approved Clinical Trial, if that care would be covered under the plan if the Covered Person was not participating in a clinical trial.

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

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

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

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

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

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

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

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

No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the Approved Clinical Trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;

- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the Approved Clinical Trial;
- An item or drug provided by the Approved Clinical Trial sponsors free of charge for any patient;
- A service, item, or drug that is provided at no charge or that is eligible for reimbursement by an entity other than Medical Mutual, including the sponsor of the Approved Clinical Trial;
- A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Dental Services for Certain Medical Conditions

Accidental Injury

Dental services will be covered for initial injuries sustained in an accident. The accidental injury must have caused damage to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an accidental injury.

The above exclusion for injuries as a result of biting or chewing shall not apply if such injury was the result of domestic violence or if an underlying medical Condition caused the biting or chewing-related injuries. For example, a Covered Person with epilepsy involuntarily clamps down on his teeth and breaks one during a seizure.

The underlying Illness must cause the chewing or biting accident that results in injury to the jaws, sound natural teeth, mouth or face. If a Covered Person has an underlying Illness that causes the teeth to be more susceptible to injury, dental services related to such injury will not be covered as an injury sustained in an accident.

Coverage may be provided for dental implants only when due to trauma, accidents or as deemed Medically Necessary by Medical Mutual.

Covered Services include (must be deemed Medically Necessary):

- oral examinations;
- x-rays;
- tests and laboratory examinations;
- restorations;
- prosthetic services;
- oral surgery;
- mandibular/maxillary reconstruction; and
- anesthesia.

Other Dental Services

Dental x-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia, will only be covered for the following:

- transplant preparation;
- initiation of immunosuppressives; and
- direct treatment of acute traumatic injury, cancer or cleft palate.

Outpatient facility charges are covered for the removal of teeth or for other dental processes only if the patient's medical Condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

Diagnostic Services

A diagnostic service is a test or procedure performed, when you have specific symptoms, to detect or monitor your Condition. It must be ordered by a Physician or Other Professional Provider. Some services may require Preauthorization. Covered diagnostic services include, but are not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- CAT scans
- Laboratory and pathology services
- Cardiographic, encephalographic, and radioisotope tests
- Nuclear cardiology imaging studies
- Ultrasound services
- Allergy tests
- Electrocardiograms (EKG)
- Electromyograms (EMG) except that surface EMG's are not Covered Services
- Echocardiograms
- Bone density studies
- Positron emission tomography (PET scanning)
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure
- Echographies
- Doppler studies
- Brainstem evoked potentials (BAER)
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies
- Muscle testing
- Electrocorticograms
- Central supply (IV tubing) or Pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Drug Abuse and Alcoholism Services

Benefits are provided for the treatment of Drug Abuse or Alcoholism. Covered Services include:

- Inpatient treatment, including rehabilitation and treatment in a Residential Treatment Facility;
- Outpatient treatment, including partial Hospitalization and intensive Outpatient services;
- detoxification services;
- individual and group psychotherapy;
- psychological testing; and
- counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Certificate. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient receiving treatment for Drug Abuse or Alcoholism.

Inpatient admissions to a Hospital Provider or Residential Treatment Facility Provider must be Preauthorized. The telephone number for Preauthorization is listed on the back of your identification card. Contracting Providers in Ohio will assure this Preauthorization is done; and since the Provider is responsible for obtaining the Preauthorization, there is no penalty to you if this is not done. For Non-Contracting Providers or Providers outside of Ohio, you are responsible for obtaining Preauthorization. If you do not Preauthorize these admissions and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges.

Drugs and Biologicals

You are covered for Prescription Drugs and biologicals that cannot be self-administered and are furnished as part of a Physician's professional service, such as antibiotics, joint injections and chemotherapy, in the course of the diagnosis or treatment of a Condition. Other drugs that can be self-administered or that may be obtained under drug coverage, if applicable, are not covered but the administration of the drug may be covered.

Drugs that can be covered under your supplemental Prescription Drug plan need to be obtained under your Pharmacy coverage.

Specialty Prescription Drugs require prior approval from Medical Mutual.

Medical Mutual, along with your Physician, will determine which setting is most appropriate for these drugs and biologicals to be administered to you.

Medical Mutual may, in its sole discretion, establish Quantity Limits and/or age limits for specific Prescription Drugs. Covered Services will be limited based upon Medical Necessity, Quantity Limits and/or age limits established by Medical Mutual or utilization guidelines. Medical Mutual may require other utilization programs, such as Step Therapy and Prior Authorization, on certain Prescription Drugs. These programs are described further below. The Medical Necessity decisions are made by going through a coverage review process.

Step Therapy: a program to determine whether you qualify for coverage based upon certain information, such as medical history, drug history, age and gender. This program requires that you try another drug before the target drug will be covered under this plan, unless special circumstances exist. If your Physician believes that special circumstances exist, he or she may request a coverage review.

Prior Authorization: a program applied to certain Prescription Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prior authorization helps promote appropriate use and enforcement of medically accepted guidelines for Prescription Drug benefit coverage.

Prior Authorization is required for most Specialty Prescription Drugs and may also be required for certain other Prescription Drugs (or the prescribed quantity of a certain Prescription Drug).

Quantity limits: Certain Prescription Drugs are covered only up to a certain limit. Quantity Limits help promote appropriate dosing of Prescription Drugs and enforce medically accepted guidelines for Prescription Drug benefit coverage. Obtaining quantities beyond the predetermined limit requires Prior Authorization.

Emergency Services

You are covered for Medically Necessary Emergency Services for an Emergency Medical Condition. Emergency Services are available 24 hours a day, 7 days a week.

In the event of an emergency:

- call 911 or go to the nearest Hospital; and
- notify Medical Mutual, by calling Customer Care at the phone number shown on your identification card, within 24 hours, or as soon as medically possible, if the nearest Hospital is not in the PPO Network.

Care and treatment once you are Stabilized are not Emergency Services. Continuation of care beyond that needed to evaluate or Stabilize your Emergency Medical Condition will be covered according to your Schedule of Benefits. Please refer to your Schedule of Benefits for a detailed coverage explanation.

Home Health Care Services

Covered Services received from a Hospital or a Home Health Care Agency include, but are not limited to:

- professional services of a registered or licensed practical nurse;
- diagnostic services;
- nutritional guidance;
- treatment by physical means, occupational and speech therapy;

- medical and surgical supplies;
- durable medical equipment;
- Prescription Drugs;
- oxygen and its administration;
- medical social services, such as the counseling of patients;
- home health aide visits when you are also receiving covered nursing or therapy services; and
- private duty nursing services.

Medical Mutual will not cover any home health care services or supplies which are not specifically listed in this Home Health Care Services section. Examples include but are not limited to:

- Physician charges;
- homemaker services;
- food or home delivered meals; and
- Custodial Care, rest care or care which is only for someone's convenience.

All Home Health Care services must be certified initially by your Physician and your Physician must continue to certify that you are receiving Skilled Care and not Custodial Care as requested by Medical Mutual. All services will be provided according to your Physician's treatment plan and as authorized as Medically Necessary by Medical Mutual.

Home Infusion Therapy Services

Benefits for home infusion therapy include a combination of nursing, Durable Medical Equipment and pharmaceutical services that are delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy.

Hospice Services

Hospice services consist of health care services provided to a Covered Person who is a patient with a reduced life expectancy due to advanced illness. Hospice services must be provided through a freestanding Hospice Facility or a hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Covered Person in a private residence.

The following Covered Services are considered hospice services:

Covered Services include, but are not limited to, the following:

- professional services of a registered or licensed practical nurse;
- diagnostic services;
- treatment by physical means, occupational therapy, speech therapy and inhalation therapy;
- medical and surgical supplies;
- durable medical equipment;
- Prescription Drugs;
- oxygen and its administration;
- medical social services, such as the counseling of patients;
- home health aide visits when you are also receiving covered nursing or therapy services;
- acute Inpatient hospice services;
- respite care;
- dietary guidance; counseling and training needed for a proper dietary program; and
- bereavement counseling for family members.

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

- **volunteer services;**
- **spiritual counseling;**
- **homemaker services;**
- **food or home delivered meals;**
- **chemotherapy or radiation therapy if other than to relieve the symptoms of a Condition; and**
- **Custodial Care, rest care or care which is only for someone's convenience.**

Inpatient Health Education Services

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

Inpatient Hospital Services

The Covered Services listed below are benefits when services are performed in an Inpatient setting, unless otherwise specified.

The following bed, board and general nursing services are covered:

- a semiprivate room or ward;
- a private room, when Medically Necessary; if you request a private room, Medical Mutual will provide benefits only for the Hospital's average semiprivate room rate;
- newborn nursery care; and
- a bed in a special care unit approved by Medical Mutual. The unit must have facilities, equipment and supportive services for the intensive care of critically ill patients.

Covered ancillary Hospital services include, but are not limited to:

- operating, delivery and treatment rooms and equipment;
- Prescription Drugs;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. We will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded.
- anesthesia, anesthesia supplies and services;
- oxygen and other gases;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services;
- therapy services; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

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

- **gowns and slippers;**
- **shampoo, toothpaste, body lotions and hygiene packets;**
- **take-home drugs;**
- **telephone and television; and**
- **guest meals or gourmet menus.**

Coverage is not provided for an Inpatient admission, the primary purpose of which is:

- **diagnostic services;**
- **Custodial Care;**
- **rest care;**

- **environmental change;**
- **physical therapy; or**
- **residential treatment (for conditions other than those related to Mental Health Care, Drug Abuse or Alcoholism).**

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

Inpatient admissions to a Hospital must be Preauthorized. The telephone number for Preauthorization is listed on the back of your identification card. Contracting Hospitals in Ohio will assure this Preauthorization is done; and since the Hospital is responsible for obtaining the Preauthorization, there is no penalty to you if this is not done. For Non-Contracting Hospitals or Hospitals outside of Ohio, you are responsible for obtaining Preauthorization. If you do not Preauthorize a Hospital admission and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges. However, if your Inpatient stay is for an organ transplant, please review the requirements under the Organ Transplant Services section.

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

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

Coverage for the Inpatient postpartum stay for the mother and the newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a caesarean section. It will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care. Please note that neither you nor your Provider is required to obtain prior approval of an Inpatient maternity stay that falls within these time frames.

Physician or advanced practice registered nurse-directed, follow-up care services are covered after discharge including:

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

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

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

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

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of Inpatient care required to be covered, at home post delivery follow up care visits are covered for you at your

residence by a Physician or nurse when performed no later than 72 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

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

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

Surrogacy: Medical Mutual will cover Maternity Services as described in this Certificate for you if you are acting as a surrogate. However, to the extent that you receive any compensation or payment from any third party, even if the compensation or payment is designated for services other than medical expenses, Medical Mutual has a right to subrogate against that compensation to the extent that it pays maternity claims under this Certificate. You are obligated to notify Medical Mutual of any compensation or payment you receive as a result of acting as a surrogate and the benefits payable hereunder are contingent on your cooperation according to this provision. No coverage will be provided for maternity services Incurred by a person not covered under this Certificate who is acting as a surrogate for you or any Dependent.

Medical Care

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

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

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

Staff consultations required by Hospital rules are not covered.

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

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

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

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

Office Visits

- Office visits and consultations to examine, diagnose and treat a Condition are Covered Services. You may be charged for missed office visits if you fail to give notice or reasonable cause for cancellation.
- Services not performed in-person (telehealth). When performed by a Provider with whom Medical Mutual has an agreement to perform these services, your coverage will include Providers' charges for consulting with Covered Persons by telephone, facsimile machine, electronic mail systems or online visit services. Online Covered Services include a medical consultation using the internet via a webcam, chat or voice. Non Covered Services include, but are not limited to, communications used for:
  - Reporting normal lab or other test results
  - Office appointment requests
  - Billing, insurance coverage or payment questions

- Requests for referrals to doctors outside the online care panel
- Benefit precertification
- Physician-to-Physician consultation

Medical Supplies and Durable Medical Equipment

This section describes supplies and equipment that are covered when prescribed by your Physician. These supplies and equipment must serve a specific therapeutic purpose in the treatment of a Condition.

Medical and Surgical Supplies - Disposable supplies which serve a specific therapeutic purpose are covered. These include:

- allergy serum extracts;
- chem strips;
- lancets;
- Clinitest
- syringes;
- needles;
- oxygen;
- ostomy bags and supplies; and
- surgical dressings and other similar items.

Items usually stocked in the home for general use are not covered. These include, but are not limited to:

- **elastic bandages;**
- **thermometers;**
- **corn and bunion pads; and**
- **Jobst stockings and support/compression stockings.**

Durable Medical Equipment (DME) - Equipment which serves only a medical purpose and must be able to withstand repeated use is covered. Upon request, your Physician must provide a written treatment plan that shows how the prescribed equipment is Medically Necessary for the diagnosis or treatment of a Condition or how it will improve the function of a malfunctioning body part. If you need to use this equipment for more than six months, your Physician may be required to recertify that continued use is Medically Necessary.

You may rent or purchase DME; however, for each Condition, Medical Mutual will not cover more in total rental costs than the customary purchase price as determined by Medical Mutual. For example, if you submit claims for the monthly rental fee and by the third month the total in rental dollars meets or exceeds the customary purchase price, you will have exhausted your benefit for that piece of Durable Medical Equipment.

When it has been determined that you require DME, before you decide whether to rent or purchase, estimate what the rental cost will be for the time period during which you will use the DME. If the estimated rental cost exceeds the purchase price, then you should consider purchasing the DME.

Covered DME includes, but is not limited to:

- crutches;
- blood glucose monitors;
- respirators;
- hemodialysis equipment;
- home dialysis equipment;
- pressure machines;
- infusion pump for IV fluids and medicine;
- cardiac, neonatal and sleep apnea monitors;
- tracheotomy tube;
- cochlear implants;

- wheelchairs;
- hospital beds;
- mastectomy bras; and
- augmentive communication devices, when approved by Medical Mutual, based on the Covered Person's Condition.

Non-covered equipment includes, but is not limited to:

- **rental costs if you are in a facility which provides such equipment;**
- **repair costs which are more than the rental price of another unit for the estimated period of use, or more than the purchase price of a new unit;**
- **Physician's equipment, such as a blood pressure cuff or stethoscope;**
- **deluxe equipment such as specially designed wheelchairs for use in sporting events; and**
- **items not primarily medical in nature such as:**
  - **an exercycle, treadmill, bidet toilet seat, elevator and chair lifts, lifts for vans for motorized wheelchairs and scooters;**
  - **items for comfort and convenience;**
  - **disposable supplies and hygienic equipment;**
  - **self-help devices such as: bedboards, bathtubs, sauna baths, overbed tables, adjustable beds, special mattresses, telephone arms, air conditioners and electric cooling units; and**
  - **other compression devices.**

Orthotic Devices - Rigid or semirigid supportive devices which limit or stop the motion of a weak or diseased body part are covered. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately. These devices include, but are not limited to:

- cervical collars;
- ankle foot orthosis;
- splints (extremity);
- slings;
- wristlets;
- custom-made shoe inserts;
- built-up shoe;
- corrective shoe with accompanying orthopedic braces;
- orthopedic shoes for diabetics;
- braces for the leg, arm, neck or back;
- trusses and supports; and
- back and special surgical corsets.

Non-covered orthotic devices include, but are not limited to:

- **garter belts, corn and bunion pads;**
- **arch supports and other foot care or foot support devices only to improve comfort or appearance. These include, but are not limited to, care for flat feet and subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails.**

Prosthetic Appliances - Your coverage includes the purchase, fitting, adjustments, repairs and replacements of prosthetic devices which are artificial substitutes and necessary supplies that:

- replace all or part of a missing body organ or limb and its adjoining tissues; or
- replace all or part of the function of a permanently useless or malfunctioning body organ or limb.

Covered prosthetic appliances include, but are not limited to:

- artificial hands, arms, feet, legs and eyes, including permanent lenses;
- appliances needed to effectively use artificial limbs or corrective braces;

- aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant);
- colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care;
- restoration prosthesis (composite facial prosthesis)
- intraocular lens implantation for the treatment of cataract, aphakia or keratoconus. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals), including frames or contact lenses, are covered when they replace the function of the human lens for Conditions caused by cataract Surgery or injury; the first pair of contact lenses or eyeglasses is a Covered Service. The donor lenses inserted at the time of Surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye, and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be Covered Services.
- soft lenses or sclera shells for use as corneal bandages when needed as a result of eye Surgery;
- Breast prosthesis whether internal or external, following a mastectomy; and
- wigs following cancer treatment.

Non-covered prosthetic appliances include, but are not limited to:

- **dentures, unless as a necessary part of a covered prosthesis;**
- **dental appliances;**
- **eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye, except as specified;**
- **replacement of cataract lenses unless needed because of a lens prescription change;**
- **deluxe prosthetics that are specially designed for uses such as sporting events.**

Mental Health Care Services

Covered Services for the treatment of Mental Illness include:

- Inpatient treatment, including treatment in a Residential Treatment Facility;
- Outpatient treatment, including partial Hospitalization and intensive Outpatient services;
- individual and group psychotherapy;
- electroshock therapy and related anesthesia only if given in a Hospital or Psychiatric Hospital;
- psychological testing;
- counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Certificate. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient;
- In addition, as provided in Medical Mutual's medical policy guidelines, certain behavioral assessment and intervention services for individual, family and group psychotherapy will also be covered for a medical Condition.

Services for developmental delay, and intellectual disability, other than those necessary to evaluate or diagnose these Conditions, are not covered.

Inpatient admissions to a Hospital Provider or Residential Treatment Facility Provider must be Preauthorized. The telephone number for Preauthorization is listed on the back of your identification card. Contracting Providers in Ohio will assure this Preauthorization is done; and since the Provider is responsible for obtaining the Preauthorization, there is no penalty to you if this is not done. For Non-Contracting Providers or Providers outside of Ohio, you are responsible for obtaining Preauthorization. If you do not Preauthorize these admissions and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges.

Organ and Tissue Transplant Services

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

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

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

Covered Services also include:

- the initial evaluation and any necessary testing to determine eligibility as a candidate for transplant; and
- the harvest and storage of bone marrow/stem cells.

Organ/Tissue Transplant Preauthorization - In order for an organ/tissue transplant to be a Covered Service, the proposed course of treatment and the Inpatient stay for the organ/tissue transplant must both be preauthorized by Medical Mutual.

PPO Providers within the SuperMed Network and Contracting Hospitals in Ohio are responsible for obtaining Preauthorization of the proposed course of treatment and the Inpatient stay. When SuperMed PPO Network Providers and Contracting Hospitals in Ohio are utilized, the penalty shown in the Schedule of Benefits entitled "Organ Transplant Penalty for failure to obtain Precertification/Prior Approval" will not apply to the Covered Person if Preauthorization is not obtained.

If the Covered Person utilizes a Provider who is not a SuperMed Provider or utilizes a Hospital outside Ohio or that is a Non-Contracting Hospital, the Covered Person is responsible for obtaining Preauthorization for both the proposed course of treatment and the Inpatient stay, and failure to do so will result in a penalty shown in the Schedule of Benefits, entitled "Organ Transplant Penalty for failure to obtain Precertification/Prior Approval." If the organ/tissue transplant is not preauthorized and is determined to not be Medically Necessary, the Covered Person may be responsible for all Billed Charges for that organ transplant.

In addition, if the organ/tissue transplant is not preauthorized and is determined to be Experimental/Investigational, the Covered Person may be responsible for all Billed Charges for that organ/tissue transplant.

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

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

Medical Mutual has established relationships with certain Transplant Centers, known as "Designated Transplant Centers". A list of these PPO Network Transplant Centers is available on request from Medical Mutual's Care Management Department. If you receive your transplant from a Designated Transplant Center, your services will be covered at the designated level of benefits for organ transplants, subject to any Deductible and Coinsurance set forth in your Schedule of Benefits. If you use a Non-Designated Transplant Center, you will be subject to a penalty of the amount set forth in your Schedule of Benefits, in addition to any applicable Coinsurance increase.

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

- donor search programs for bone marrow/stem cell transplants;
- evaluation of the organ/tissue;
- removal of the organ/tissue from the donor;
- transportation of the organ/tissue to the Transplant Center; and
- treatment of immediate post-operative complications and Medically Necessary care from the donor procedure.

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

Transportation and Lodging Benefits - Your coverage includes benefits for related reasonable and necessary travel expenses, including meals and lodging, for the transplant recipient and a family member or two family members if the patient is under age 18, subject to any limitations set forth in the Schedule of Benefits. These additional benefits are available only if the member's Immediate Family lives more than 75 miles from the approved transplant facility. Excluded from this Transportation and Lodging benefit are: child care; mileage within the transplant city; rental cars, buses, taxis or shuttle service, except as specifically approved; frequent flyer miles; coupons, vouchers or travel tickets; prepayments or deposits; services for a Condition that is not directly related to, or a direct result of, the transplant; telephone calls; laundry; postage; entertainment; interim visits to a medical facility while waiting for the actual transplant procedure; travel expenses for donor companion/caregiver; and return visits for the donor for a treatment of a Condition found during evaluation.

Medical Mutual does not provide organ/tissue transplant benefits for services, supplies or Charges:

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

Other Outpatient Services

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

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

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

Respiratory/Pulmonary Therapy - Treatment by the introduction of dry or moist gases into the lungs, including, but not limited to, inhalation treatment (pressurized and non-pressurized) for acute airway obstruction or sputum induction for diagnostic purposes.

Outpatient Institutional Services

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

Covered Institutional services include, but are not limited to:

- operating, delivery and treatment rooms and equipment;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. We will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded.
- anesthesia, anesthesia supplies and services; and

- surgically inserted prosthetics such as pacemakers and artificial joints.

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

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

Outpatient Rehabilitative and Habilitative Services

Rehabilitative therapy services and supplies are used for a person to regain or prevent deterioration of a skill that has been lost or impaired due to illness, injury or disabling Condition. Habilitative therapy services are services and devices that help a person keep, learn or improve skills and functioning for daily living. Therapy services must be ordered by a Physician or Other Professional Provider to be covered. Covered Services are limited to the therapy services listed below:

Habilitative Services - Habilitative therapy services include, but are not limited to, habilitative services to children under age 21 with a diagnosis of Autism Spectrum Disorder, which sometimes includes:

- Speech/language therapy and occupational therapy performed by licensed therapists;
- Clinical therapeutic intervention, including, but not limited to, applied behavioral analysis. The analysis must be provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of Ohio to perform the services in accordance with a treatment plan; and
- Mental/behavioral health Outpatient services performed by a licensed psychologist, psychiatrist or Physician to provide consultation, assessment, development and oversight of treatment plans.

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

Hyperbaric Therapy - The provision of pressurized oxygen for treatment purposes.

No benefits will be provided for the following therapy services once a patient can no longer significantly improve from treatment for the current Condition unless it is determined to be Medically Necessary by Medical Mutual, and in no event will treatment be covered if the number of visits exceeds the limit set forth in the Schedule of Benefits, even if it is Medically Necessary.

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

Occupational Therapy - Occupational therapy services are covered if it is expected that the therapy will result in a significant improvement in the level of functioning.

All occupational therapy services must be performed by a certified, licensed occupational therapist or another Provider who has a license or certification under state law that allows him or her to perform such services.

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

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

All physical therapy services must be performed by a certified, licensed physical therapist or another Provider who has a license or certification under state law that allows him or her to perform such services.

Speech Therapy - In order to be considered a Covered Service, this therapy must be performed by a certified, licensed therapist and be Medically Necessary due to a speech impairment.

Pediatric Vision Services

This section describes the services and supplies available to Covered Persons under age 19 only. This benefit will terminate at the end of the month following the Covered Person's nineteenth (19th) birthday. These services and supplies must be provided and billed by Providers and must be Medically Necessary unless otherwise specified.

The following Routine Vision Care Services are covered:

Vision Examinations - Medical Mutual will cover comprehensive examination, including dilation.

Lenses and Frames - Medical Mutual will cover prescribed Lenses and Frames:

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 - 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.

Coverage is not provided for (in addition to those non-covered items listed in the "Exclusions" section of this Certificate):

1. Services or materials which are rendered prior to your effective date.
2. Services and materials Incurred after the termination date of your coverage.
3. For Lenses which are not prescribed.
4. For the replacement of Lenses or Frames except as specified in the Schedule of Benefits.
5. For safety glass and safety goggles.
6. That Medical Mutual determines are special or unusual; such as orthoptics, vision training and low vision aids, unless otherwise specified.
7. 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).
8. For non-covered services or services specifically excluded in the text of this Certificate.

Physical Medicine and Rehabilitation Services

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

Coverage is also provided for day rehabilitation program services received in a day Hospital for physical medicine and rehabilitation. A day rehabilitation program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, two or more days a week at day Hospital.

Prescription Drug Services

Unless otherwise indicated, the paragraphs within this benefit apply to Prescription Drugs received from both retail Pharmacies and through the Home Delivery Program. Prescription Drugs not listed on the Formulary are generally not covered. See below for more information.

Medical Mutual will provide benefits for Medically Necessary Prescription Drug Covered Services that are dispensed for your Outpatient use. All Prescription Drugs and refills must be prescribed by a Physician or other Professional Provider who is licensed by his or her state to write prescriptions ("Prescriber").

Specialty Prescription Drugs are covered under this benefit when obtained through Medical Mutual's Contracting Specialty Pharmacy(ies) and are limited to a maximum of a thirty (30) day supply. Specialty Prescription Drugs require prior approval from Medical Mutual.

Medical Mutual may, in its sole discretion, establish Quantity Limits and/or age limits for specific Prescription Drugs. Covered Services will be limited based upon Medical Necessity, Quantity Limits and/or age limits established by Medical Mutual or utilization guidelines. Medical Mutual may require other utilization programs, such as Step Therapy and Prior Authorization, on certain Prescription Drugs. These programs are described further below. The Medical Necessity decisions are made by going through a coverage review process. More information on this coverage review process can be found in the Prescription Drug benefit member material sent separately. You may also call Customer Service at the phone number shown on your identification card for details.

Step Therapy: a program to determine whether you qualify for coverage based upon certain information, such as medical history, drug history, age and gender. This program requires that you try another drug before the target drug will be covered under this plan, unless special circumstances exist. If your Physician believes that special circumstances exist, he or she may request a coverage review.

Prior Authorization: a program applied to certain Prescription Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prior authorization helps promote appropriate use and enforcement of medically accepted guidelines for Prescription Drug benefit coverage.

Prior Authorization is required for most Specialty Prescription Drugs and may also be required for certain other Prescription Drugs (or the prescribed quantity of a certain Prescription Drug).

Quantity limits: Certain Prescription Drugs are covered only up to a certain limit. Quantity Limits help promote appropriate dosing of Prescription Drugs and enforce medically accepted guidelines for Prescription Drug benefit coverage. Obtaining quantities beyond the predetermined limit requires Prior Authorization.

Prior approval for chronic Conditions: For the purposes of this section, "chronic Condition " means a medical Condition that has persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six (6) continuous months.

Medical Mutual will honor a prior authorization approval for an approved drug related to a chronic Condition for the lesser of the following from the date of the approval:

1. Twelve (12) months;
2. The last day of the Covered Person's eligibility under the plan.

This 12-month approval is no longer valid and automatically terminates if there are changes to federal or state laws or federal regulatory guidance or compliance information prescribing that the drug in question is no longer approved or safe for the intended purpose. In addition, this 12-month approval does not apply to any of the following:

1. Medications that are prescribed for a non-maintenance Condition;
2. Medications that have a typical treatment of less than one (1) year;
3. Medications that require an initial trial period to determine effectiveness and tolerability beyond which a one-year, or greater, prior authorization period will be given;
4. Medications where there is medical or scientific evidence that do not support a 12-month prior approval;
5. Medications that are a schedule I or II controlled substance or any opioid analgesic or benzodiazepine;
6. Medications that are not prescribed by a PPO Network Provider as part of a care management program.

Nothing in this section prohibits the substitution of any drug that has received a 12-month approval when there is a release of a U.S. FDA-approved comparable brand product or a generic counterpart of a brand product that is listed as therapeutically equivalent by the FDA.

Prior authorization, or one of Medical Mutual's other utilization programs, is required for opioid analgesics prescribed for the treatment of chronic pain, unless the drug is prescribed under one of the following circumstances:

1. To a Covered Person who is a Hospice Facility patient in a Hospice care program;
2. To a Covered Person who has been diagnosed with a terminal Condition but is not a Hospice Facility patient in a Hospice care program;
3. To a Covered Person who has cancer or another Condition associated with the Covered Person's cancer of history of cancer.

Benefits will be provided based on the Allowed Amount. The Covered Person's Deductible, Copayments or Coinsurance is based upon the amount charged by the Pharmacy and does not include any rebates received by Medical Mutual. The Covered Person is responsible for any Deductible, Copayment, or Coinsurance amounts specified in the Schedule of Benefits. The requirement to pay the applicable cost sharing (Deductible, Copayments or Coinsurance) cannot be waived by a Provider, a Pharmacy or anyone else under any "fee forgiveness," "not out-of-pocket," "discount program," "coupon program" or similar arrangement. Additionally, applicable cost sharing amounts cannot be paid for using funds from a patient assistance program, regardless if the member is receiving such assistance due to financial need from a pharmaceutical manufacturer, government program, or a charitable organization. Pharmaceutical manufacturers may sponsor patient assistance programs (PAPs) that provide financial assistance or drug free products (through in-kind product donations) to low income individuals to augment any existing prescription drug coverage. If you receive any amount from a patient assistance program or if a Provider, a Pharmacy or anyone else waives the required cost sharing (Deductible, Copayments, Coinsurance) for a particular claim, the cost sharing amounts covered by the patient assistance program or waived shall not be considered as true out-of-pocket expenses for Covered Persons, and these amounts shall not apply to Deductibles and/or Out-of-Pocket Maximums.

If the Prescription Drug or injectable insulin Allowed Amount is less than the Prescription Drug Copayment, your liability is limited to the Allowed Amount only.

You are required to present your identification card to the Pharmacy each time you obtain Prescription Drugs. If you do not present your identification card, or you do not go to a Network Pharmacy, you may pay a higher price for your Prescription Drugs or be responsible for Excess Charges.

Medical Mutual, in its sole discretion, may limit benefits for Prescription Drugs, if the only clinical results are deemed to be lifestyle improvements and not necessary for the cure or prevention of disease, illness, or injury.

Your coverage also provides benefits for:

- certain preventive drugs required by PPACA when a written prescription from your Prescriber is received. These PPACA-required drugs are covered at a zero Copayment, but specific ages and Quantity Limits apply.
- Contraceptives. (A religious organization, as defined by the federal government, is permitted to exclude contraceptive benefits from coverage. Contact your customer service representative at the phone number shown on your ID card if you have questions.)
- injectable medications, if self-administered.
- injectable insulin, needles and syringes are covered whether or not they are prescribed.

If your Prescriber has not required the drug to be dispensed as written (DAW), you may inquire if Generic Prescription Drug or Preferred Brand Name Prescription Drug substitutes are available.

If a Brand Name Prescription Drug is purchased when a Generic Prescription Drug is available, you will be responsible for the difference between the cost of the Generic and Brand Name Prescription Drugs, in addition to any other member cost sharing, as described in the Schedule of Benefits.

An off-label Prescription Drug will not be excluded for a particular indication on the grounds that the drug has not been approved by the FDA for the particular indication if the drug is recognized for safe and effective treatment of the indication for which the drug was prescribed in at least one (1) standard medical reference compendia adopted by the U.S. Department of Health and Human Services or in other qualified medical literature. "Medical literature" means:

- Two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed;
- No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed;
- Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services as acceptable peer-reviewed medical literature.

However, no benefits will be provided if:

- the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
- the drug has not been approved for any indication by the FDA;
- the drug is not included in the Formulary or list of covered drugs provided by Medical Mutual.

Exceptions for Certain Situations

- **Brand Name Prescription Drugs vs. Generic Prescription Drugs:**

  There may be occasions when a Brand Name Prescription Drug, as opposed to its corresponding Generic Prescription Drug, is more appropriate. If Medical Mutual, after receiving supporting documentation from your Physician, determines the Brand Name Prescription Drug is medically appropriate, you will be charged your Brand Name Prescription Drug Copayment. To obtain more information regarding this process, please contact a customer service representative by calling the number listed on your ID card.

  How Brand Name/Generic Incentives apply to Contraceptives:

  With regard to Contraceptives, Step Therapy may be applied to single-source drugs to encourage use of a generic equivalent drug. In this situation, the Covered Person may be required to share in the cost of the Contraceptive. However, if the Covered Person's attending Physician determines a particular service or FDA-approved item is required for medical reasons, Medical Mutual will cover that Contraceptive service or item without cost sharing. The Physician will need to complete our medical necessity waiver form which considers factors such as severity of side effects, differences in permanence and reversibility of Contraceptives, and the ability to adhere to the appropriate use of the item or service.

  A determination on this exception process will be made according to the timeframe and in a manner that takes into account the nature of the claim (e.g., pre-service or post-service) and the medical exigencies involved for a claim involving urgent care.

- **Non-Formulary Prescription Drugs:**

  This plan uses a Prescription Drug Formulary. Prescription Drugs not listed on the Formulary are generally not covered. However, the Covered Person, or his or her designee/Physician (or other prescriber, as appropriate), can ask Medical Mutual to make an exception to cover a particular non-Formulary drug. For standard reviews, the Covered Person, or his or her designee, and the Covered Person's Physician (or other prescriber) will be notified of Medical Mutual's determination by Medical Mutual within 72 hours following receipt of the request containing information sufficient to complete the review. For an exigent circumstance (defined below), an expedited review can be requested. For expedited reviews, the Covered Person, or his or her designee, and the Covered Person's Physician (or other prescriber) will be notified of Medical Mutual's determination by Medical Mutual within 24 hours following Medical Mutual's receipt of the request containing information sufficient to complete the review. If the decision to exclude the drug is upheld, the Covered Person, or his or her designee/Physician (or other prescriber, as appropriate), may also request that a denied exception request be reviewed by an Independent Review Organization (IRO). The Covered Person, or his or her designee, and the Covered Person's Physician (or other prescriber) will be notified of the IRO's determination within 72 hours, for a standard review, and 24 hours for an expedited review, from Medical Mutual's receipt of the request containing information sufficient to complete the review. If an exception request is granted by either Medical Mutual or an IRO, the non-Formulary drug and its refills will be covered for the duration of the Prescription or, for an exigent circumstance, for the duration of the exigency; in addition, the Covered Person's cost sharing for that drug will accumulate toward the Covered Person's PPO Network Out-of-Pocket Maximum.

  "Exigent circumstance" means a Covered Person either has a Condition that may seriously jeopardize his or her life, health, or ability to regain maximum function or is undergoing a current course of treatment using a non-Formulary medication. The request for an expedited review should include the following support:

  - Information related to the existence of the exigency and a description of the harm that could reasonably occur to the Covered Person if the requested drug is not provided in the timeframe; and
  - Justification supporting the need for the non-Formulary Prescription Drug to treat the Covered Person's Condition, including a statement that all covered Formulary Prescription Drugs, on any tier, will be or have been ineffective, are less effective, or would result in adverse effects.

Coverage during active military duty:

If you are called to active military duty, you may obtain a supply of your prescribed medications for the number of months needed in order to meet your needs during a time of emergency. You would be required to contact Medical Mutual, explain the situation and provide your name, identification number, the medications that need to be filled and the number of months supply needed.

Home Delivery Program

Benefits for Home Delivery Prescription Drugs provide the convenience of receiving Prescription Drugs delivered directly to your home. A Home Delivery Prescription Drug is a Prescription Drug which can be provided by a Contracting Home Delivery Pharmacy and must be taken for an extended period of time in order to treat a certain medical Condition.

To receive Home Delivery Prescription Drug benefits, mail your Prescription Drug Order and the amount you owe for Copayments, Deductibles and/or Coinsurance, to a Contracting Home Delivery Pharmacy, as specified in the Schedule of Benefits. No benefits are payable if your Prescription Drug Order is sent to a Non-Contracting Home Delivery Pharmacy.

The Contracting Home Delivery Pharmacy will fill your Prescription Drug Order and send you a supply for the number of days indicated in the Prescription Drug Schedule of Benefits. The Contracting Home Delivery Pharmacy will dispense the medication and mail it to you within seven days. If the Contracting Home Delivery Pharmacy fails to send you the Home Delivery Prescription Drug within ten days after you mailed in your Prescription Drug Order, you may call the Contracting Home Delivery Pharmacy directly to determine the status of the Prescription Drug Order.

Prescription Drug Exclusions for Retail and Home Delivery (in addition to those non-covered items listed in the "Exclusions" section of this Certificate)

Coverage is not provided for:

1. Drugs not covered on the Formulary, except as described in the Prescription Drug Services benefit.
2. Drugs dispensed for cosmetic purposes or used solely for beautifying or altering one's appearance in the absence of any underlying Condition.
3. Therapeutic devices.
4. Artificial appliances.
5. Lost, stolen or damaged Prescriptions.
6. Prescription Drugs that have been determined by Medical Mutual to be abused or otherwise misused.
7. More than the number of Prescription Drug refills specified by the Prescriber.
8. Any refill of a Prescription Drug dispensed after the length of time allowed by laws.
9. Charges for more than the days supply of a Prescription Drug, as specified in the Prescription Drug Schedule of Benefits.
10. Incurred or received after you stop being a Covered Person.
11. Fees for administering or injecting Prescription Drugs, except for vaccines covered under PPACA.
12. Erectile dysfunction drugs, except agents that are approved by the FDA for Conditions other than erectile dysfunction, such as Cialis for treatment of benign prostatic hypertrophy.
13. For lifestyle improvement drugs not necessary for the cure or prevention of disease, illness or injury, except as may be required by PPACA.
14. Compound medications in which the active ingredients do not require a Prescription Order or are not determined to be Medically Necessary.
15. Diagnostic, imaging and test agents and devices except for those used for blood glucose testing, or diabetes.
16. Treatment of onychomycosis (toenail fungus).
17. Treatment of infertility, either through injectable or oral medication.
18. Prescription Drugs that have an over-the-counter equivalent available, except as may be required by PPACA.
19. Enteral or parenteral therapy, except as provided under the Home Infusion Therapy benefit.
20. Medical food, nutritional or dietary supplements or supplies.
21. Drug used to decrease weight gain or appetite control, or to treat obesity.
22. Minerals and vitamins, unless required by PPACA.
23. Refilled prescriptions if less than 75% of the original prescriptions (or subsequent refill) has been used.

Private Duty Nursing Services in conjunction with Home Health Care

The services of a registered nurse, licensed vocational nurse or licensed practical nurse when ordered by a Physician are covered only as provided as part of home health care. These services include skilled nursing services received in a patient's home. Your Physician must certify all services initially and continue to certify that you are receiving Skilled Care and not Custodial Care as requested by Medical Mutual. All Covered Services will be provided according to your Physician's treatment plan and as authorized by Medical Mutual. Nurse's notes must be sent in with your claim.

Private duty nursing services do not include care which is primarily nonmedical or custodial in nature such as bathing, exercising or feeding. Also, Medical Mutual does not cover services provided by a nurse who usually lives in your home or is a member of your Immediate Family.

All private duty nursing services must be certified by your Physician initially and every two weeks thereafter, or more frequently if required by Medical Mutual, for Medical Necessity.

Routine and Preventive Services

Routine and preventive services will be covered under this plan, as required under federal and state law. In accordance with those laws and their associated guidance, limitations on coverage may apply, based upon the Covered Person's actual Condition, age, gender and the frequency of the service.

The following categories of preventive services are covered without application of a Deductible, Copayment or Coinsurance, when provided by a PPO Network Provider:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration (HRSA).
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

  Examples of preventive services that fall within the above categories are:

  - Health Education Services
    - Diabetic Self-Management Training and Education Services - are Covered Services when provided under the supervision of a licensed health care professional with expertise in diabetes. These services help to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diet and medical nutrition therapy.
    - Behavioral Counseling to Promote a Healthy Diet - Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases.
  - Routine Gynecological Services
    - Mammogram services

      The total benefit for a screening mammography under this plan, regardless of the number of claims submitted by Providers, will not exceed one hundred thirty percent (130%) of the Medicare reimbursement rate in the state of Ohio for a screening mammography. If a Provider, Hospital, or other health care facility provides a service that is a component of the screening mammography and submits a separate claim for that component, a separate payment shall be made to the Provider, Hospital or other health care facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. The benefit paid for mammography constitutes full payment under this Certificate. No Provider, Hospital, or other health care facility shall seek or received compensation in excess of the payment made that corresponds to the ratio paid by Medicare in Ohio, except for approved Deductibles, Copayments or Coinsurance.

    - PAP tests
  - Routine Physical Examinations
  - Routine Screenings
    - blood glucose screenings and screening for type 2 diabetes
    - bone density screenings for women
    - chlamydia screenings, limited to pregnant and sexually active women
    - cholesterol screenings
    - colorectal cancer screenings; using fecal occult blood testing, sigmoidoscopy or colonoscopy
    - hepatitis B virus screenings; limited to pregnant women in their first prenatal visit
  - Smoking cessation services
  - Well child care services

- Women's preventive services
  - These services include, but not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; Contraceptives and counseling for Contraceptives for women with reproductive capacity; sterilization procedures; breastfeeding; and domestic violence.

    (A religious organization, as defined by the federal government, is permitted to exclude Contraceptive benefits from coverage. Contact your customer service representative at the phone number shown on your ID card if you have questions).

Please refer to the phone number on the back of your identification card if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/coverage/preventive-care-benefits. Newly added preventive services added by the advisory entities referenced by the Affordable Care Act will start to be covered on the first plan year beginning on or after the date that is one year after the new recommendations or guideline, went into effect. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of eligible services.

Other covered preventive services that may be subject to a Deductible, Copayment and/or Coinsurance are:

- Routine Prostate Specific Antigen (PSA) Tests
- Routine Testing, meaning laboratory, x-ray and medical testing services.

Skilled Nursing Facility Services

The benefits available to an Inpatient of a Hospital listed under the Inpatient Hospital Services section are also available to an Inpatient of a Skilled Nursing Facility. These services must be Skilled Care, and your Physician must certify all services initially and continue to certify that you are receiving Skilled Care and not Custodial Care as requested by Medical Mutual. All Covered Services will be provided according to your Physician's treatment plan and as authorized by Medical Mutual.

No benefits are provided:

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

Surgical Services

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

- diagnostic endoscopic procedures, such as colonoscopy and sigmoidoscopy;
- implantation of a cochlear device;
- maxillary or mandibular frenectomy;
- removal of bony impacted teeth;
- sterilization (A religious organization, as defined by the federal government, is permitted to exclude sterilization benefits from coverage. Contact your customer service representative at the phone number shown on your ID card if you have questions.);
- therapeutic abortions.

Reconstructive Services - Benefits include reconstructive Surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include Surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this plan.

Note: Coverage for reconstructive services does not apply to orthognathic Surgery.

Surgery performed primarily to improve appearance, also known as cosmetic Surgery, is not covered.

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

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

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

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

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

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

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

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

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

Temporomandibular Joint Syndrome Services

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (health and neck muscle) disorders.

Urgent Care Services

Benefits are provided when you receive Covered Services from an Urgent Care Provider for health problems that require immediate attention which are not Emergency Medical Conditions are considered to be Urgent Care needs. Determination as to whether or not Urgent Care Services are Medically Necessary will be made by Medical Mutual.

Examples of Urgent Care are:

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

EXCLUSIONS

In addition to the exclusions and limitations explained in the Health Care Benefits section, 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. Not Medically Necessary or do not meet Medical Mutual's policy, clinical coverage guidelines, or benefit policy guidelines.
4. Received from other than a Provider.
5. For Experimental or Investigational drugs, devices, medical treatments or procedures, except as specified.
6. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
7. For a Condition that occurs as a result of any act of war, declared or undeclared.
8. For a Condition resulting from direct participation in a riot, civil disobedience, nuclear explosion or nuclear accident.
9. For which you have no legal obligation to pay in the absence of this or like coverage.
10. 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.
11. Received from a member of your Immediate Family.
12. Incurred after you stop being a Covered Person except as specified in the Benefits After Termination of Coverage section.
13. For the following:
    - physical examinations or services required by an insurance company to obtain insurance;
    - physical examinations or services required by a governmental agency such as the FAA and DOT;
    - physical examinations or services required by an employer in order to begin or to continue working.

    This exclusion does not apply to those covered preventive services remaining under this plan, unless the expense for such service is paid for by another source.
14. For X-ray examinations with no preserved film image or digital record.
15. 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.
16. For which benefits are payable under Medicare Part B or would have been payable if a Covered Person had applied for Part B, 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.
17. Received in a military facility for a military service related Condition.
18. For court-ordered testing or care unless Medically Necessary.
19. For Surgery and other services primarily to improve appearance (including removal of tattoos) or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss or weight loss Surgery), except as specified. This exclusion does not apply to medical complications directly related to such Surgery or other services. "Medical complications" include, but are not limited to, myocardial infarction, pulmonary embolism, thrombophlebitis and exacerbation of co-morbid Conditions.
20. For Surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment.
21. For weight loss Surgery and any repairs, revisions or modifications of such Surgery, including weight loss device removal. This exclusion does not apply to medical complications directly related to such Surgery, repairs, revisions or modifications. "Medical complications" include, but are not limited to, myocardial infarction, excessive

nausea/vomiting, pneumonia and exacerbation of co-morbid medical Conditions during the procedure or in the immediate post-operative time frame.

22. For dietary and/or nutritional counseling or training, except as specified or required by PPACA.
23. For treatment of Conditions related to developmental delay, intellectual disabilities, hyperkinetic syndromes or behavioral problems, except as specified.
24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss, except as specified.
25. For marital counseling.
26. For the medical treatment of sexual problems not caused by a biological Condition.
27. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
28. For male Contraceptives and over-the-counter birth control without a prescription.
29. For treatment of infertility, including, but not limited to, artificial insemination, in vitro fertilization, Gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT), as well as any medication prescribed to induce ovulation or spermatogenesis.
30. For reverse sterilization.
31. For elective abortions.
32. For dental x-rays, supplies and appliances and associated expenses, including hospitalization and anesthesia, except as described in the "Dental Services for Certain Medical Conditions" benefit.
33. For dental implants.
34. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
35. For personal hygiene and convenience items.
36. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except as described in the "Pediatric Vision" benefit and in the section entitled "Prosthetic Appliances" under the "Medical Supplies and Durable Medical Equipment" benefit.
37. 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), except as specified.
38. For hypnosis and acupuncture.
39. For biofeedback.
40. For blood which is available without charge. For Outpatient blood storage services.
41. For routine services, except as described in the "Routine, Preventive and Wellness Services" benefit.
42. For arch supports and other foot care or foot support devices only to improve comfort or appearance which include, but are not limited to, care for flatfeet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails.
43. For specialized camps.
44. For water aerobics.
45. For hearing aids or examinations for prescribing or fitting them, unless otherwise specified within this Certificate.
46. For private duty nursing services rendered in a Hospital or Skilled Nursing Facility.
47. For massotherapy or massage therapy.
48. For treatment of gynecomastia (male breast enlargement).
49. For treatment of hyperhidrosis (excessive sweating).
50. For sclerotherapy.
51. For the Institutional charges and Physician charges related to non-emergency use of an emergency room.
52. For missed appointments, completion of claim forms or copies of medical records.
53. For telephone consultations or consultations via electronic mail, facsimile or internet/website, except as required by law, authorized by Medical Mutual, or as otherwise described in this Certificate.
54. For charges for doing research with Providers not directly responsible for your care.
55. For stand-by charges of a Physician.
56. For any Charges not documented in Provider records.
57. For services as the result of an injury or illness caused by or contributed to by engaging in an assault or felony.

58. For fraudulent or misrepresented claims.
59. For a particular health service in the event that a Non-PPO Network or Non-Contracting Provider waives Deductibles, Copayments, or Coinsurance, no benefits are provided for the health service for which the Deductibles, Copayments, or Coinsurance are waived.
60. 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. Most Providers will submit a claim for you; if you submit it yourself, you should use a claim form. In most cases, you can obtain a claim form from your Group or Provider. If your Provider does not have a claim form, Medical Mutual will send you one. Call or notify Medical Mutual, in writing, within 20 days after receiving your first Covered Service and we will send you a form, or you may print a claim form by going to www.medmutual.com/member.

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

Proof of Loss

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

Medical Mutual is not legally obligated to reimburse for Covered Services unless written or electronically submitted proof that Covered Services have been given to you is received. Proof must be given within 90 days of your receiving Covered Services or as soon as is reasonably possible. Except in the absence of legal capacity, no proof can be submitted later than one year from the time proof is otherwise required.

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

Medicare Eligibility

Your benefits under this Certificate may be reduced if you are eligible for Medicare Part B but do not enroll in and maintain that coverage.

Your benefits under this Certificate may also be reduced if you are enrolled in a Medicare Advantage (Medicare Part C) plan but fail to follow the rules of that plan.

Benefits under this Certificate are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances, Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under this Certificate.

If you are eligible for or enrolled in Medicare Part B, please read the following information carefully.

If you are entitled to Medicare because you are over age 65, and your employer employs fewer than 20 employees; or if you are entitled to Medicare due to disability and your employer employs fewer than 100 employees, Medicare will be the primary payer, that is, Medicare must pay benefits before the group health plan pays benefits.

If you are eligible for Medicare Part B on a primary basis (Medicare pays before benefits are provided under this Certificate), you **should** enroll for and maintain coverage under Medicare Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer, we will pay benefits under this Certificate as if you were covered under

Medicare Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before benefits under this Certificate), you should follow all rules of that plan that require you to seek services from that plan's participating Providers. When we are the secondary payer, we will pay any benefits available to you under this Certificate as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

How Claims are Paid

You have a choice when selecting a Provider. This plan provides coverage for PPO Network Providers, other Contracting Providers and Non-Contracting Providers. However, the type of Provider you choose to utilize can have a large impact on your out-of-pocket expenses. Please review the following descriptions for additional information.

PPO Network and other Contracting Providers

Medical Mutual has agreements with Providers both inside and outside the PPO Network, both of which are referred to as Contracting Providers. While the highest level of benefits is provided when you obtain Covered Services from PPO Network Providers, both PPO Network Providers and other Contracting Providers have agreed not to 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. The Allowed Amount is the lesser of the applicable Negotiated Amount or the Covered Charge. Refer to the Schedules of Benefits to determine the amount of Copayments, Deductibles and Coinsurance that apply when utilizing PPO Network Providers versus other Contracting Providers and Non-Contracting Providers.

Non-Contracting Providers

If you choose to obtain services from a Non-Contracting Provider, your out-of-pocket expenses will likely be significantly higher than what you would pay by choosing a PPO Network Provider. Copayments, Deductibles and Coinsurance are usually higher when utilizing a Non-Contracting Provider, as shown on the Schedules of Benefits. Also, Medical Mutual calculates its payments to Non-Contracting Providers based upon the Non-Contracting Amount. This means that in addition to your increased out-of-pocket expenses described above, you may also be responsible for Excess Charges, up to the amount of the Provider's Billed Charges. This is sometimes referred to as "balance billing." Excess Charges billed by Non-Contracting Providers DO NOT apply to the Out-of-Pocket Maximum.

If you obtain Covered Emergency Services from a Non-Contracting Provider, Medical Mutual pays for benefits in an amount equal to the greatest of the following:

1. The Negotiated Amount. If more than one amount is negotiated with Contracting Providers for the Emergency Service, the amount payable is the median of these amounts.
2. The Non-Contracting Amount.
3. The amount that would be paid under Medicare for the Emergency Service.

Any charges exceeding the Allowed Amount, Non-Contracting Amount or the amount payable for Emergency Services received from a Non-Contracting Provider described above will not apply toward any Deductible, Out-of-Pocket Maximum or benefit maximum accumulation.

Your Financial Responsibilities

You are responsible for:

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

Deductibles, Copayments, Coinsurance and amounts paid by other parties do not accumulate towards Out-of-Pocket Maximums.

Benefit Period Deductible

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

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

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

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

Coinsurance

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

Copayments

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

Out-of-Pocket Maximum

This is the amount of Copayments, Deductibles and Coinsurance for which Covered Persons are responsible each Benefit Period for Covered Services. After the applicable Out-of-Pocket Maximum shown in the Schedule of Benefits has been met, no additional Copayments, Deductibles or Coinsurance are required from Covered Persons for Covered Services for the remainder of the Benefit Period, unless otherwise specified in this Certificate. The Out-of-Pocket Maximum does not include expenses other than Copayments, Deductibles and Coinsurance (e.g., premium, charges for services not covered under this plan, penalties for non-compliance with plan provisions, etc.).

Deductible and Out-of-pocket Credit

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

Schedule of Benefits

The Deductible(s) and Out-of-Pocket 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 and Medical Mutual's Negotiated Amounts.

Provider Status and Direction of Payment

Medical Mutual has agreed to make payment directly to PPO Network and Contracting Providers for Covered Services.

Some of Medical Mutual's contracts with Providers, including Institutional Providers, allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual, and Medical Mutual will retain any payments resulting therefrom; however, the Deductibles, Copayments, Coinsurance, and benefit maximums, if applicable, will be calculated based upon the Allowed Amount, as described in this Certificate.

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 Contracting and/or PPO Network.

Medical Mutual is authorized 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, including your Provider.

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

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

Prior Approval of Benefits received from Non-PPO Network or Non-Contracting Providers

In some cases, Medical Mutual may determine that certain Covered Services can only be provided by a Non-PPO Network or Non-Contracting Provider. If Covered Services provided by a Non-PPO Network or Non-Contracting Provider are approved in advance by Medical Mutual, benefits will be provided as if the Covered Services were provided by a PPO Network Provider. However, Non-Contracting Providers may not accept our Allowed Amount as payment in full, and you may have to pay the Excess Charges.

To obtain prior approval of treatment by a Non-PPO Network or Non-Contracting Provider, your PPO Network Provider must provide Medical Mutual with:

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

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

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

Preauthorization Notice for Covered Persons Utilizing Non-Contracting Providers or Residing Outside the State of Ohio

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

Preauthorization from Medical Mutual must be obtained for Inpatient admissions to a Hospital and for certain Outpatient tests, procedures and equipment. If the Hospital or your Provider does not preauthorize the admission or Outpatient service, you must obtain Preauthorization by calling the Medical Mutual telephone number on your identification card at least two days prior to receiving an Outpatient service or your admission to the Hospital. In the event Preauthorization is not obtained, and services from a Non-Contracting Provider are determined to not be Medically Necessary, you will be responsible for all Billed Charges for those services, whether Inpatient or Outpatient.

In the event of an Emergency Admission, the Hospital, you, a family member or your representative must notify Medical Mutual within 48 hours or two working days of admission, or as soon as reasonably possible, or you may be responsible for all Billed Charges for that Emergency Admission, if that admission is determined to not be Medically Necessary.

Examples of Outpatient tests, procedures and equipment that may require Preauthorization are:

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

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

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

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

Explanation of Benefits

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

Time of Payment of Claims

Benefits will be provided under this 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.

Foreign Travel

Benefits include coverage for the treatment of Emergency Medical Conditions rendered worldwide. Your coverage is in effect whether your treatment is received in a foreign country or in the United States. When you receive medical treatment in another country, you may be asked to pay for the service at the time it is rendered. To receive reimbursement for the care provided, make sure to obtain an itemized bill from the Provider at the time of service. Medical Mutual cannot process a bill unless the Provider lists separately the type and cost of each service you received. All billing submitted for consideration must be translated into the English language and dollar amounts converted to the current rate of exchange.

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

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of Medical Mutual, Medical Mutual will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of Medical Mutual, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of Medical Mutual, disability affecting a significant number of a PPO Network Provider's staff or similar causes, or health care services provided under this Certificate are delayed or considered impractical. Under such circumstances, Medical Mutual and PPO Network

Providers will provide the health care services covered by this Certificate as far as is practical under the circumstances, and according to their best judgment. However, Medical Mutual and PPO Network Providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of Medical Mutual.

Filing a Complaint

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, the 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 Group Contract, the Customer Service representative will telephone the Certificate Holder with the response. If attempts to telephone the Certificate Holder are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the Certificate Holder will receive a check, Explanation of Benefits or letter explaining the revised decision.

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

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

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

Benefit Determination for Claims (Internal Claims Procedure)

Claims Involving Urgent Care

Generally, 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. With respect to prior authorization requests submitted by health care practitioners (as defined in Ohio Revised Code 3923.041(A)) through Medical Mutual's electronic software system only, a Claim Involving Urgent Care also means a claim for Medical Care or other service for a Condition where the application of the timeframes for making non-urgent care determinations (a) could seriously jeopardize the life, health, or safety of the claimant or others due to the claimant's psychological state; of (b) in the opinion of a practitioner with knowledge of the claimant's medical or behavioral condition, would subject the claimant to adverse health consequences without the care or treatment that is the subject of the request.

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

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

If you do not follow Medical Mutual's procedures or we do not receive sufficient information 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.

If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a Claim Involving Urgent Care through Medical Mutual's electronic software system, Medical Mutual will respond to the request within 48 hours of receipt and indicate whether the request is denied, approved, or if additional information is needed to process the request.

If additional information is needed to process the request, Medical Mutual will notify the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) within 24 hours of receipt of the Claim Involving Urgent Care and the health care practitioner will have 48 hours to respond. Because we are required to make a decision within 48 hours after receipt of the Claim involving Urgent Care, your claim may still be denied when we request additional information.

Concurrent Care Claims

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

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

Pre-Service Claims

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

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

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

If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a Pre-Service Claim through Medical Mutual's electronic software system, Medical Mutual will respond to the request within 10 days of receipt and indicate whether the request is denied, approved, or if additional information is needed to process the request. If additional information is needed to process the request, the health care practitioner will then have 45 days to respond with the additional information. If your health care practitioner does not provide the information, your claim may be denied.

For only those prior authorization requests that are submitted by a health care practitioner (as defined in Ohio Revised Code 3923.041(A)) through Medical Mutual's electronic software system that are approved by Medical Mutual, except in cases of fraudulent or materially incorrect information, Medical Mutual will not retroactively deny a prior authorization for a health care service, drug, or device when all of the following are met: (1) the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a prior authorization request to Medical Mutual for a health care service, drug, or device; (2) Medical Mutual approves the prior authorization request after determining that all of the following

are true: (a) the claimant is eligible under the health benefit plan; (b) the health care service, drug, or device is covered under the claimant's health benefit plan; and (c) the health care service, drug, or device meets Medical Mutual's standards for medical necessity and prior authorization; (3) the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) renders the health care service, drug, or device pursuant to the approved prior authorization request and all of the terms and conditions of the health care practitioner's contract with Medical Mutual; (4) on the date the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) renders the prior approved health care service, drug, or device, all of the following are true: (a) the claimant is eligible under the health benefit plan; the claimant's condition or circumstances related to the claimant's care has not changed; (c) the health care practitioner submits an accurate claim that matches the information submitted by the health care practitioner in the approved prior authorization request; and (5) if the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a claim that includes an unintentional error and the error results in a claim that does not match the information originally submitted by the health care practitioner in the approved prior authorization request, upon receiving a denial of services from Medical Mutual, the health care practitioner may resubmit the claim with the information that matches the information included in the approved prior authorization.

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.

If you file a Post-Service Claim for a service where prior authorization was required but not obtained, upon written request, Medical Mutual shall permit a retrospective review if the service in question meets all of the following: (i) the service is directly related to another service for which the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submitted a prior authorization request through Medical Mutual's electronic software system, prior approval has already been obtained from Medical Mutual on such request, and the original prior authorized service has already been performed; (ii) the new service was not known to be needed at the time the original prior authorized service was performed; and (iii) the need for the new service was revealed at the time the original authorized service was performed. Once the written request and all necessary information is received, Medical Mutual will review the claim for coverage and medical necessity. Medical Mutual will not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question.

Adverse Benefit Determination Notices

You will receive notice of a benefit determination, orally as allowed, or in writing in a culturally and linguistically appropriate manner. All notices of an Adverse Benefit Determination will include the following:

- Information sufficient to identify the claim or health care service involved, including the health care provider, the date of service, and claim amount, if applicable;
- the specific reason(s) for the Adverse Benefit Determination;
- reference to the specific plan provision(s) on which the Adverse Benefit Determination is based;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of Medical Mutual's appeal procedures and applicable timeframes, including the expedited appeal process, if applicable;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of your right to bring a civil action under federal law following an Adverse Benefit Determination after review on appeal, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA);
- disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance;

- if an internal rule, guideline, protocol or similar criteria was relied upon in making the Adverse Benefit Determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the Adverse Benefit Determination was based on Medical Necessity, Experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

Filing an Internal Appeal and External Review

I. Definitions

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

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

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

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

Covered Service - please refer to the definition of this term in the Definitions Section earlier in this Certificate.

Covered Person - please refer to the definition of this term in the Definitions Section earlier in this Certificate.

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

Emergency Services - please refer to the definition of this term in the Definitions Section earlier in this Certificate.

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

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

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

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

the benefits that such an entity is contracted to administer under a Health Benefit Plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the Superintendent.

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

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

Stabilize - please refer to the definition of this term in the Definitions Section earlier in this Certificate.

Superintendent - the superintendent of insurance.

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

II. How to File an Appeal

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

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

To submit an appeal electronically, go to Medical Mutual's Web site, 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; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, documents, dental X-rays or photographs you would like considered in the appeal. Send or fax the letter and records to:

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

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

III. Internal Appeals Procedure

A. Mandatory Internal Appeal Level

The Plan provides all members a mandatory internal appeal level. You must complete this mandatory internal appeal level before any additional action is taken, except when exhaustion is unnecessary as described in the following sections.

Mandatory internal appeals must be filed within 180 days from your receipt of a notice of Adverse Benefit Determination. All requests for appeal may be made by submitting an electronic form, by calling Customer Service or in writing as described above in the How to File an Appeal section.

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

All determinations that involve, in whole or in part, issues of Medical Necessity, whether services are Experimental and Investigational, or any other medical judgment, are based on the evaluations and opinions of health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior evaluations about your claim and will not be a subordinate of the professional who made the initial evaluation of your claim. These health

care professionals act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits. Upon specific written request from you, Medical Mutual will provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

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

If, during the appeal, Medical Mutual considers, relies upon or generates any new or additional evidence, you will be provided free of charge with copies of that evidence before a notice of Final Adverse Benefit Determination is issued. You will have an opportunity to respond before our time frame for issuing a notice of Final Adverse Benefit Determination expires. Additionally, if Medical Mutual decides to issue a Final Adverse Benefit Determination based on a new or additional rationale, you will be provided that rationale free of charge before the final notice of Final Adverse Benefit Determination is issued. You will have an opportunity to respond before our timeframe for issuing a notice of Final Adverse Benefit Determination expires.

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

1. **Types of Mandatory Internal Appeals and Timeframes**

   a. **Appeal of Claim Involving Urgent Care**

   - You, your Authorized Representative or your Provider may request an appeal of a claim involving urgent care. The appeal does not need to be submitted in writing. You, your Authorized Representative, or your Physician should call the Care Management telephone number on your identification card as soon as possible. Appeals of claims involving urgent care typically involve those claims for Medical Care or treatment with respect to which the application of the time periods for making non-urgent care determinations (1) could seriously jeopardize the life or health of a patient, or the ability of the patient to regain maximum functions, or (2) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The appeal must be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request to appeal. If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) uses Medical Mutual's electronic software system to request an appeal of a Claim Involving Urgent Care, Medical Mutual will respond to the appeal within 48 hours of receipt. The expedited appeal process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

   b. **Pre-Service Claim Appeal**

   - You or your Authorized Representative may request a pre-service claim appeal. Pre-service claim appeals are those requested when you have received a denial of a Pre-Service Claim in advance of you receiving Medical Care. The pre-service claim appeal must be requested within 180 days of the date you received notice of an Adverse Benefit Determination but before you have received the service. When Medical Mutual receives a pre-service claim appeal in writing, it must be decided within a reasonable amount of time appropriate to the medical circumstances, but not later than 30 days after the receipt of the request. When Medical Mutual receives a pre-service claim appeal from your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) when you have authorized him or her to appeal on your behalf and the health care practitioner uses Medical Mutual's electronic software system for prior authorization, Medical Mutual will respond to the appeal within 10 calendar days of receipt.

   c. **Post Service Claim Appeal**

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

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

   All notices of a Final Adverse Benefit Determination after an appeal will be culturally and linguistically appropriate and will include the following:

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

B. What Happens After the Mandatory Internal Appeal Level

If your claim is denied at the mandatory internal appeal level, you may be eligible for either the External Review Process by an Independent Review Organization for Adverse Benefit Determinations involving medical judgment or the External Review Process by the Ohio Department of Insurance for contractual issues that do not involve medical judgment.

IV. External Review Process

A. Contact Information for Filing an External Review

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

B. Understanding the External Review Process

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

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

C. Opportunity for External Review

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

1. **External Review by an IRO**

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

   - The Adverse Benefit Determination involves a medical judgment or is based on any medical information
   - The Adverse Benefit Determination indicates the requested service is Experimental or Investigational, the requested Health Care Service is not explicitly excluded in the Covered Person's Health Benefit Plan, and the treating physician certifies at least one of the following:
     - Standard Health Care Services have not been effective in improving the condition of the Covered Person
     - Standard Health Care Services are not medically appropriate for the Covered Person
     - No available standard Health Care Service covered by Medical Mutual is more beneficial than the requested Health Care Service.

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

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

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

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

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

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

D. Request for External Review

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

of appeal but later decide to proceed to an external review before the voluntary appeal process has concluded, you may submit a request for external review without waiting for the voluntary appeal decision.

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

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

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

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

E. IRO Assignment

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

F. Reconsideration by Medical Mutual

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

G. IRO Review and Decision

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

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

- A general description of the reason for the request for external review
- The date the Independent Review Organization was assigned by the Ohio Department of Insurance to conduct the external review
- The dates over which the external review was conducted
- The date on which the Independent Review Organization's decision was made
- The rationale for its decision

- References to the evidence or documentation, including any evidence-based standards, that were used or considered in reaching its decision

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

H. Binding Nature of External Review Decision

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

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

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

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

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, Ohio 43215-4186
Telephone: 800.686.1526 / 614-644-2673
Fax: 614-644-3744
TDD: 614-644-3745

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

Claim Review

Consent to Release Medical Information - Denial of Coverage

You consent to the release of medical information to Medical Mutual 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. Medical Mutual has the right to refuse to reimburse for Covered Services if you refuse to consent to the release of any medical information.

Right to Review Claims

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

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

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

Physical Examination

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

Legal Actions

No action, at law or in equity, shall be brought 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. You may also submit an appeal, as further described in the section entitled "Filing an Internal Appeal and External Review." 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.

Changes In Benefits or Provisions

The benefits provided by this coverage may be changed at any time. If there is a material change during the policy year, you will be notified 60 days in advance of the changes. It is your Group's responsibility to notify you when these changes go into effect. If you are receiving Covered Services under this Certificate at the time your revised benefits become effective, Medical Mutual will continue to provide benefits for these services only if they continue to be Covered Services under the revised benefits.

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

Termination of Coverage

How and When Your Coverage Stops

Your coverage stops:

- By termination of the Group Contract including termination for non-payment. This automatically ends all of your coverage. It is the responsibility of your Group to notify you of such termination.
- On the date a Covered Person insured as a spouse stops being an Eligible Dependent.
- At the end of the month during which a Covered Person insured as a child stops being an Eligible Dependent.
- On the date that the Certificate Holder becomes ineligible.
- At the end of the period for which the premium was made when a Covered Person does not pay the next required contribution.
- On the day a final decree of legal separation, divorce, annulment or dissolution of the marriage is filed, a Certificate Holder's spouse will no longer be eligible for coverage.
- On the date a Certificate Holder's Domestic Partnership terminates, the Domestic Partner will cease to be eligible for coverage.
- Immediately upon notice if:
  - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
  - a Covered Person intentionally misrepresents a material fact provided to Medical Mutual or commits fraud or forgery. If Medical Mutual rescinds your coverage, you will be given 30 days' advance written notice, during which time you may request a review of the decision.

Federal Continuation Provisions - COBRA

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

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

When You Are Eligible for COBRA

If you are a Certificate Holder and active employee covered under your employer's group health plan, you have the right to choose this continuation coverage if you lose your group health coverage because of reduction in your hours of employment or termination of employment (for reasons other than gross misconduct on your part) or at the end of a leave under the Family and Medical Leave Act. If you are a covered retiree, you have the right to continuation coverage if your employer has filed for reorganization under Chapter 11 of the Bankruptcy Code.

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

1. the death of your spouse;

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

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

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

Notice Requirements

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

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

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

How Long COBRA Coverage Will Continue

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

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

If you are a former employee and you have a newborn or adopted child while you are on COBRA continuation and you enroll the new child for coverage, the new child will be considered a "qualified beneficiary". This gives the child additional rights such as the right to continue COBRA benefits even if you die during the COBRA period. Also, this gives the right to an additional 18-month coverage if a second qualifying event occurs during the initial 18-month COBRA period following your termination or retirement. If you are entitled to 18 months of continuation coverage and if the Social Security Administration determines that you were disabled within the 60 days of the qualifying event, you are eligible for an additional 11 months of continuation coverage after the expiration of the 18-month period. To qualify for this additional period of coverage, you must notify the group within 60 days after becoming eligible for COBRA or receiving a disability determination from the Social Security Administration, whichever is later. Such notice must be

given before the end of the initial 18 months of continuation coverage. If the individual entitled to the disability extension has non-disabled family members who are qualified beneficiaries and have COBRA coverage, those non-disabled beneficiaries will also be entitled to this 11-month disability extension. During the additional 11 months of continuation coverage, the premium for that coverage may be no more than 150% of the coverage cost during the preceding 18 months provided to similarly situated active employees.

The law also provides that your continuation coverage may be terminated for any of the following four (4) reasons:

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

Additional Information

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

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

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

State Continuation Provisions

Note: Domestic Partners and dependents of Domestic Partners are not eligible for continuation of group benefits. In this section Eligible Dependents under State Continuation means the Certificate Holder's spouse, and eligible dependent children of the Certificate Holder or the Certificate Holder's spouse.

If the Certificate Holder's coverage stops due to an involuntary termination of employment, and the termination of employment is not a result of any gross misconduct on the part of the Certificate Holder, the Certificate Holder may be eligible to continue group coverage. The Certificate Holder is eligible for continuation of group benefits when at the time of termination the Certificate Holder meets all of the following criteria:

- continuously covered by the Group Contract or a similar contract for the three month period immediately prior to termination of employment;
- not eligible for nor covered by Medicare; and
- not eligible for any other group medical coverage.

If the Certificate Holder is eligible for continuation of group benefits, coverage for the Certificate Holder and his/her Eligible Dependents may continue for up to 12 months following termination of employment. This continuation of coverage applies only to health coverage and is contingent upon the Certificate Holder's payment of the required premium.

Continuation of Coverage During Military Service

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

- the date you return to reserve status from active military duty;

- 24 months from the date continuation began (or 36 months if any of the following occurs during this 24-month period: death of the reservist; divorce or separation of a reservist from the reservist's spouse; or a child ceasing to be an Eligible Dependent);
- the date coverage terminates under the Certificate for failure to make timely payment of a required contribution;
- the date the entire Certificate ends; or
- the date the coverage would otherwise terminate under the Certificate.

Benefits After Termination of Coverage

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

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

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

Rescission of Coverage

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the plan began to provide you with coverage, just as if you never had coverage under the plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

Multi-Language Interpreter Services & Nondiscrimination Notice

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

Spanish

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

Chinese

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

German

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

Arabic

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

Pennsylvania Dutch

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

Russian

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

French

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

Vietnamese

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

Navajo

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

Oromo

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

Korean

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

Italian

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

Japanese

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

Dutch

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

Ukrainian

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

Romanian

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

Tagalog

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

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

Nondiscrimination Notice

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

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

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

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

Email: CivilRightsCoordinator@MedMutual.com

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

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

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