LEGACY HEALTH SERVICES

Group Number
559528-500-513

Health Care Benefit Book

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 SERVICES, LLC

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

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SUMMARY PLAN DESCRIPTION

THE INFORMATION FOUND IN THE SUMMARY PLAN DESCRIPTION IS NOT A PART OF YOUR CERTIFICATE AND/OR BOOKLET

GENERAL INFORMATION:

Name of Plan:	Legacy Health Services - Group Health Plan
Plan Sponsor:	Legacy Health Services 12380 Plaza Dr Parma, OH 44130
Type of Plan:	Welfare Plan providing medical benefits
Type of Administration and Funding Medium:	The Plan is self-funded by the Plan Sponsor. The cost of the annual premium for the plan is paid in part by the Plan Sponsor out of its general assets and in part by employees who have an option to pay their share of the annual premium with pre-tax payroll deductions. The Plan Sponsor will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time. Medical Mutual, 100 American Road, Cleveland, Ohio 44114, 1-800-523-8558 has been hired to process claims under the Plan. Medical Mutual does not serve as an insurer but merely as a claims processor. Medical Mutual requests and receives funds from the Plan Sponsor to pay the claims. The Plan Sponsor is ultimately responsible for providing the benefits under the Plan. The Plan Sponsor and Medical Mutual share the responsibility for administering the Plan. Benefits are paid directly out of the general assets of the Plan Sponsor.
Plan Administrator:	Legacy Health Services 12380 Plaza Drive Parma, OH 44130
Service of Legal Process:	May be made upon the Plan Administrator, Legacy Health Services.
Employer ID Number:	34-1663174
Plan Number:	502
Plan Year:	January 1 - December 31

Plans Sponsor (sometimes referred to as your/the Group) maintains the Plan to provide medical benefits to its eligible employees and their spouses and dependents. The Plan provides benefits through the following component benefits programs:

Medical

- Standard
- Value

This document, together with any attachments, and the Benefits Book for each component plan constitute the Plan Document and Summary Plan Document required by ERISA. If you think there may be a conflict between the terms of this document and the Benefits Book, please ask the Plan Administrator for clarification. Generally, the terms of the Benefits Book will govern.

This Summary Plan Description (SPD) contract is attached to a copy of the Benefits Book which contains a detailed description of the benefits and limitations under the Plan and the conditions that must be satisfied before the benefits are payable. If your copy is misplaced, you may obtain a replacement copy from the Plan Administrator at no additional cost.

In order to receive any benefits (1) you must be covered under the Plan (2) you must incur a loss or expense for which a benefit is payable (3) the loss or expense must be incurred during a period of time and under the conditions specified by the Group, and (4) a claim must be filed for any benefit payable.

Please refer to the "Schedule of Benefits" in your Benefits Book for descriptions of the following: deductibles, coinsurance and copayment amounts for which you or your beneficiary will be responsible; any annual or lifetime caps or other limits on benefits under the plan; the extent to which preventive services are covered under the plan; whether, and under what circumstances, coverage is provided for medical tests, devices and procedures; provisions governing the use of the network providers and whether, and under what circumstances, coverage is provided for out-of-network services; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the Plan.

Please refer to the "Prescription Drug Rider" in your Benefits Book for descriptions on whether, and under what circumstances, existing or new drugs are covered under the Plan.

Your provider network under the Plan is a PPO (Preferred Provider Organization). Provider lists are furnished automatically, without charge, as a separate document.

ELIGIBILITY FOR PLAN PARTICIPATION:

After working as a Regular Employee for the applicable waiting period, Regular Employees and their eligible spouses and dependents are eligible to participate in the Plan. A Regular Employee is one who regularly works a minimum of 30 hours per week and is performing the duties of an employee for the Plan Sponsor. The applicable waiting period is based upon the employment class in which your position is classified. The Plan Administrator will inform you as to your applicable waiting period. If a current non-eligible employee becomes a Regular Employee, the employee will be eligible to participate in the Plan the first of the month following the date his/her status changed as long as the waiting period for his/her employment class has been met. A summary of the waiting periods follows:

CLASSES	ELIGIBILITY WAITING PERIOD
Professional	Minimum 30 hours/week. Coverage begins the 1st of the month following 30 days.
Staff	Minimum 30 hours/week. Coverage begins the 1st of the month following 30 days

Once you are eligible to participate in the Plan, you must complete an enrollment form to participate in the Plan. Additional eligibility requirements for employee, spouse and eligible dependent Plan participation are outlined in your Benefits Book in the section titled "Eligibility".

An exclusion period may apply if you have a preexisting condition. Refer to "Preexisting Condition Exclusion Period" in your Benefits Book for details.

LOSS OF BENEFITS:

Circumstances under which you may be disqualified from the Plan, ineligible for benefits or have benefits denied/forfeited/suspended/reduced are outlined in the "Termination of Coverage", "Claim Review" and "Subrogation and Reimbursement" sections of your Benefits Book.

PROCEDURE FOR AMENDING THE PLAN:

Your Group may amend the Plan from time to time and will provide written notice of such changes to Plan participants.

CLAIMS PROCEDURE:

Your Benefits Book includes information on reporting claims. The Benefits Book is furnished automatically without charge. You may obtain claim forms from your Human Resource Department.

Please see the "General Provisions" section of your Benefits Book for information on claims filing and the appeal procedure.

FUTURE OF THE PLAN:

Benefits under your medical Plan if applicable, are paid for on a year-to-year basis. The Group reserves the right to change or end the Plan at any time. The Group's decision to change or end the Plan may be due to changes in federal or state laws governing welfare benefits, the requirements of the Internal Revenue Code or ERISA, the provisions of a contract or policy involving an insurance Group or any other reason. A Plan change may transfer Plan assets and debts to another Plan or split the Plans into two or more parts. If the Group does make a change like this or decides to end the

Plans, it may decide to set up different Plans providing similar or identical benefits or it may decide not to provide benefits at all.

If the Plan is ended (or if there is a transfer of assets and debts or a Plan split-up), you will not be vested in any Plan benefits or have any further rights (other than payment of covered expenses you had before the Plan ended). The amount and form of any final benefit you may receive will depend on Plan assets, any contract or insurance provisions affecting the Plan and Group decisions.

Because contributions of the Plan will stop on the date the Plan ends, the amount of Plan assets will be determined as of the termination date. Retired employees and beneficiaries who are receiving coverage or benefits under the Plan will stop being covered and receive no more benefits if the Plan is terminated.

YOUR EMPLOYMENT

Your eligibility or your right to benefits under the Plan should not be interpreted as a guarantee of employment. Your Group's employment practices are made without regard to the benefits they offer as part of your total compensation.

SPECIAL ENROLLMENT PERIODS

1. If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. This special rule applies if you or your dependents lose the other coverage due to termination of employment, change in employment status, termination of the other Plan's coverage, cessation of the employer's contribution toward coverage, exhaustion of COBRA coverage, death of a spouse or divorce.
2. 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 dependents, provided that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption. If you are eligible for coverage, but do not enroll, your dependent cannot enroll.

BENEFITS DURING FAMILY AND MEDICAL LEAVE OR PREGNANCY DISABILITY LEAVE

If you are on a leave of absence, approved by your employer and your leave is protected under the federal Family and Medical Leave Act (FMLA), you may continue all health benefits during such leave of absence. Contact the Human Resource Department for details on eligibility for, terms and conditions of, an approved leave of absence or if you want to request FMLA leave.

While an employee is on FMLA leave, your Group will continue to pay its regular share of the medical and/or dental insurance premium if applicable, (for individual or dependent coverage) up to a maximum of 12 weeks within a 12 month period. Benefits which are not continued during FMLA leave will be reinstated with no waiting period or preexisting condition limitation, if the employee returns to work at the end of FMLA leave.

CONTINUING BENEFITS DURING MILITARY LEAVE

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

1. If your military leave period is less than 31 days you have the right to continue medical coverage for yourself and dependents who were covered under the group medical plan for up to 30 days at a cost of not more than the cost for a similarly situated active employee.
2. If the military leave period is more than 30 days you have the right to elect COBRA continuation coverage for yourself and your dependents who were covered under the group medical plan.

COBRA CONTINUATION RIGHTS

COBRA is a federal law that allows Plan participants to continue medical and/or dental coverage if applicable, under specified circumstances where such group coverage would otherwise be lost. To continue coverage, you or your covered dependents must apply for continuation coverage and pay the required premium before the deadline for payment. COBRA coverage can extend for 18, 29 or 36 months, depending on the particular "qualifying event" which gave rise to COBRA.

WHEN YOU ARE ELIGIBLE FOR COBRA

If you are an employee and are covered under the 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 an employee (or retiree for number 5 below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the 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 the Plan on the day before the commencement of bankruptcy proceedings and was retired from the employer.

In the case of a covered dependent child of an employee (or retiree for number 6 below) covered by the Plan, he or she has the right to continuation coverage if group health coverage under the Plan is lost for any of the following six (6) reasons:

1. The death of the covered parent;
2. The termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment.
3. Covered parent's divorce or legal separation;
4. The covered parent becomes entitled (that is, covered) under Medicare;
5. The dependent ceases to be a "dependent child" under the Plan; or
6. The covered parent is retired and the covered parent's employer files for reorganization under Chapter 11 of the Bankruptcy Code.

NOTICE REQUIREMENTS

Under COBRA, the employee or a family member has the responsibility to inform the Group of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of any such event. If notice is not received within that 60 day period, the dependent will not be entitled to choose continuation coverage.

Your Group has the responsibility to notify the Plan Administrator of the employee's death, termination of employment, reduction of hours or Medicare entitlement.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator 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 the Plan Administrator 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 which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified.

HOW LONG COBRA COVERAGE WILL CONTINUE

COBRA requires that you be offered the opportunity to maintain continuation coverage for 18 months if you lost coverage under the Plan due to the employee's termination (for reason other than gross misconduct) or reduction in work hours. An employee's covered spouse and/or dependents are required to be offered the opportunity to maintain continuation coverage for 36 months if coverage is lost under the Plan because of an event other than the employee'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 employee) to their own continuation coverage (for example, the former employee dies, is divorced or legally separated, becomes entitled to Medicare or the dependent ceased to be a "dependent child" under the Plan) the continuation coverage may be extended for the affected qualified beneficiary. However, in no case will any period of continuation coverage be more than 36 months.

As of January 1,1997, 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" rather than merely an after acquired dependent. This gives the child additional rights such as the right to continue COBRA benefits even if you die during the COBRA period. Also, this gives the right to an additional 18 month coverage if a second qualifying event occurs during the initial 18 month COBRA period following your termination or retirement.

If you are entitled to 18 months of continuation coverage and if Social Security Administration determines that you were disabled within the 60 days of the qualifying event, you are eligible for an additional 11 months of continuation coverage after the expiration of the 18 month period. To qualify for this additional period of coverage, you must notify the Plan Administrator within 60 days after receiving a disability determination from the Social Security Administration. Such notice must be given before the end of the initial 18 months of continuation coverage. As of January 1,1997, 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. This rule applies even if your qualifying event occurred before January 1, 1997.

The law also provides that your continuation coverage may be cut short 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

A spouse or dependent child who is a qualified beneficiary is entitled to elect continuation of coverage even if the covered employee does not make that election. At subsequent open enrollments, a spouse or dependent child may elect a different coverage from the coverage the employee 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 Plan. However, conversion coverage is not available if the Group's contract terminates or the employer goes out of business. Call the Plan Administrator during your last 180 days of COBRA for information on conversion).

POST-MASTECTOMY RECONSTRUCTIVE SURGERY

If you receive benefits in connection with a mastectomy and elect breast reconstruction in connection with the mastectomy, the law provides for coverage for:

- Reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance and
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

You and your attending physician will determine the manner in which these procedures will be performed, in accordance with the Plan's provisions.

This coverage is subject to the same annual deductibles and coinsurance provisions that apply to other benefits under the Plan.

MATERNITY MINIMUM STAY PROVISIONS

The Newborns' and Mothers' Health Protection Act generally prohibits group health plans and health insurance issuers offering group insurance coverage from:

1. Restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section or
2. Requiring that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

The law generally does not prohibit the mothers' and newborns' attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 46 hours (or 96 hours, as applicable).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) may require medical coverage for an employee's child who would not otherwise be covered. A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee. QMCSOs usually apply to a child whose parents get divorced or who is born out of wedlock. When the Group, as Plan Sponsor, receives a QMCSO, they must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified". If the order is "qualified" and the employee must provide coverage for his/her child pursuant to the QMCSO, the amount necessary to pay for such coverage will be deducted from the employee's paycheck. The affected employee will be notified, once determination is made, whether or not the order is qualified.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
2. Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.
4. Continue health coverage for yourself, spouse or dependents, if there is a loss of coverage, under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description (SPD) and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Group's health plan, if you have creditable coverage from another Plan. You should be provided a Benefit Book and/or booklet of creditable coverage, free of charge, from your Group's health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request material from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in in part, you may file suit in a state or Federal court. *In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical and child support order, you may file suit in Federal court.* If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory of the Division of Technical Assistance and

Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C., 20210.

MEDICAL MUTUAL®

This Amendment modifies the coverage described in your Benefit Book and is effective on May 1, 2022. It is subject to all the terms and conditions of the Plan, except as stated. This Amendment terminates concurrently with the Plan to which it is attached. Please place this Amendment with your Benefit Book for future reference.

1. The following Health Care Benefit is added, or if already included in the Plan, it is modified as follows:

   Autism Spectrum Disorders

   Benefits are payable for the screening, diagnosis, and treatment of autism spectrum disorders. Covered Services include:

   - Speech/language therapy, occupational therapy and physical therapy performed by a licensed therapist.
   - Clinical therapeutic intervention which includes, but is not limited to, applied behavior analysis. This intervention must be provided by, or be under the supervision of, a Professional who is licensed, certified, or registered by an appropriate agency of Ohio to perform such services in accordance with a treatment plan.
   - Mental/behavioral health Outpatient services performed by a licensed Psychologist, psychiatrist, or Physician providing consultation, assessment, development, or oversight of treatment plans.
   - Prescription Drugs.

   Treatment for autism spectrum disorders means evidence-based care and related equipment prescribed or ordered for a Covered Person diagnosed with an autism spectrum disorder by a licensed Physician who is a developmental pediatrician or a licensed Psychologist trained in autism who determines the care to be Medically Necessary.

   All Covered Services must be prescribed or ordered by either a developmental pediatrician or a Psychologist trained in autism spectrum disorders and require Preauthorization.

2. The Health Care Benefit entitled, "Mental Health Care Services" is amended as follows:

   Reference to "developmental delay" and "intellectual disability" is replaced with "learning disabilities."

3. The term "gender dysphoria treatment" is replaced with "gender affirming Surgery."

4. Any reference to an exclusion for the treatment of autism is deleted.

5. The General Exclusion for Outpatient educational, vocational or training services, if included in the Plan, is deleted and replaced with the following:

   For educational services, including special education and remedial education, vocational services, recreational services, other non-clinical services, or services provided for training purposes, except as may be required by PPACA.

6. The General Exclusion for learning disorders, if included in the Plan, is deleted and replaced with the following:

   For treatment of learning disabilities, other than treatment necessary to evaluate or diagnose these Conditions.

7. The following General Exclusion is added:

   Wilderness therapy, therapeutic living communities (including therapeutic farms), adventure-based therapy or similar programs.

IN WITNESS
WHEREOF:

Medical Mutual Services, LLC

Steven C. Glass
President & CEO

(HMO/EPO)

This Amendment modifies the coverage described in your Benefit Book and is effective on January 1, 2022, unless stated otherwise. It is subject to all the terms and conditions of the Plan, except as stated. This Amendment terminates concurrently with the Plan to which it is attached. Please place this Amendment with your Benefit Book for future reference.

1. The following is added to the Schedule of Benefits:

   While this Plan provides coverage for HMO/EPO Network Providers only, there may be times when you have no control over whether the Provider rendering the service is in the HMO/EPO Network. Refer to the "No Surprise Billing" section under General Provisions for more information.

   The Federal No Surprises Act and Ohio's House Bill 388 establish patient protections, including surprise bills from Non-HMO/EPO Network Providers ("balance billing") for emergency care and other specified items or services. We will comply with these new state and federal requirements, as applicable, including how we process claims from certain Non-HMO/EPO Network Providers.

2. The Definitions section is amended as follows:
   a. The definition of "Emergency Services" is deleted and replaced with the following:

      Emergency Services - a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, or the Independent Freestanding Emergency Department, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient, regardless of the department of the Hospital in which such further examination or treatment is furnished; and appropriate transfers undertaken prior to an Emergency Medical Condition being Stabilized.

      "Emergency Services" also includes services for which benefits are provided under the Plan and that are furnished by a Non-HMO/EPO Network Provider (regardless of the department of the Hospital in which such items or services are furnished) after the Covered Person is Stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished.

   b. The following definition is added:

      Independent Freestanding Emergency Department - a health care facility that:

      - Is geographically separate and distinct and licensed separately from a Hospital under applicable State law; and
      - Provides any Emergency Services.

3. The Health Care Benefit entitled, "Emergency Services" is deleted and replaced with the following:

   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, whether inside or outside the Service Area.

   In the event of an emergency:

   - call 911 or go to the nearest Hospital or Independent Freestanding Emergency Department; and

- notify Medical Mutual or your Primary Care Physician, if applicable, within 24 hours, or as soon as medically possible, if the nearest Hospital or Independent Freestanding Emergency Department is not in the HMO/EPO Network.

Emergency Services do not require Prior Authorization and are payable at the HMO/EPO Network level of benefits shown in the Schedule of Benefits, regardless of whether these services are obtained from an HMO/EPO Network Provider or a Non-HMO/EPO Network Provider. You are not required to pay additional amounts for Covered Services beyond any Copayments, Deductibles or Coinsurance shown on the Schedule of Benefits. Should you receive a bill or have to pay for services, please submit the bill to Medical Mutual.

If Medical Mutual requires your transfer to an HMO/EPO Network Provider, your transportation expenses are covered in full. The sooner Medical Mutual is notified about your Condition, the sooner Medical Mutual can become involved with your care and relay vital information to the attending Physician.

If you obtain covered Emergency Services from a Non-HMO/EPO Network Provider, Medical Mutual pays for benefits in an amount equal to the greatest of the following:

- The applicable amount Medical Mutual has negotiated with HMO/EPO Network Providers. If more than one amount is negotiated with HMO/EPO Network Providers for the Emergency Service, the amount payable is the median of these amounts.
- The maximum amount allowed by Medical Mutual for Covered Services provided to Medical Mutual Covered Persons by a Non-HMO/EPO Network Provider. That amount will likely be less than the Provider's Billed Charges.
- The amount that would be paid under Medicare for the Emergency Service.

Services are no longer considered "Emergency Services" when all of the following conditions are met:

- The Covered Person's Provider determines the Covered Person is able to travel using nonmedical transportation or nonemergency medical transportation to an available HMO/EPO Network Provider located within a reasonable travel distance, taking into consideration the Covered Person's medical Condition.
- The Covered Person's Provider satisfies the notice and consent criteria of the applicable federal or state law prohibiting balance billing as well as any guidance subsequently issued thereto.
- The Covered Person is in a condition to receive the notice and consent information and provide an informed consent, thereby giving up his or her rights to be protected from balance billing for the Emergency Services.

4. The General Provisions are amended as follows:
   a. The following provision is added:

      No Surprise Billing

      "Surprise billing" is an unexpected bill that can happen when you can't control who is involved in your care; for example, when you have an emergency, or when you schedule a visit to an HMO/EPO Network Provider but are unexpectedly treated by a Non-HMO/EPO Network Provider.

      You have protection against surprise billing and balance billing for the services described below ONLY. Non-HMO/EPO Network Providers cannot balance bill you for these services; however, you are still responsible for paying any Copayments, Deductibles or Coinsurance due under this Plan. The amount of that cost-sharing will be based upon the HMO/EPO Network level of benefits and will accumulate toward your HMO/EPO Network Out-of-Pocket Maximum.

      - Emergency Services
      - Air ambulance Covered Services received from a Non-HMO/EPO Network Provider
      - Unanticipated Covered Services received from a Non-HMO/EPO Network Provider at an HMO/EPO Network Hospital or ambulatory surgical center. This means: 1) items and services related to Emergency Services; 2) anesthesia, pathology, radiology, lab and neonatology; 3) items and services provided by an assistant surgeon, hospitalist, or intensivist; 4) diagnostic services, including radiology and lab services; 5) items and services provided by a Non-HMO/EPO Network Provider, but only if there is no HMO/EPO Network Provider who can furnish the item or service at that facility; and 6) any additional services required by applicable state or federal law or subsequent guidance issued thereto.

Remember that, outside of the services described above, this Plan does not cover services received from Non-HMO Network Providers. Should you elect to knowingly and purposefully seek care from a Non-HMO Network Provider and voluntarily give consent for services for which you can be balance billed, you will be responsible for ALL charges related to services received from that Non-HMO Network Provider. Before you can consent to be balance billed, your Non-HMO Network Provider must give you, or your authorized representative, a written notice, in advance of performing the service, that includes detailed information designed to ensure that you knowingly accept all out-of-pocket charges. The notice must also include an estimate of the Provider's charge for the services.

b. The following provision is added:

Continuity of Care when a Provider's Contract with Medical Mutual Ends without Cause

If a Provider's contract with Medical Mutual ends:

1. Medical Mutual will notify each Covered Person enrolled in the Plan who is a Continuing Care Patient of that Provider at the time of termination of his or her right to elect continued transitional care under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under the Plan had such termination not occurred, with respect to the course of treatment furnished by the Provider to the Continuing Care Patient.
2. When Medical Mutual is notified of the Continuing Care Patient's need for transitional care, Medical Mutual will determine if the Continuing Care Patient is eligible for a transition period. Such period will continue for ninety (90) days from the date the Continuing Care Patient was notified of the Provider's contract ending or when the Continuing Care Patient is no longer a Continuing Care Patient, whichever occurs first.

   For the purpose of this provision, the definitions of "Continuing Care Patient" and "Serious and Complex Condition" are shown below.

   Continuing Care Patient means an individual who, with respect to a Provider or facility:

   - Is undergoing a course of treatment for a Serious and Complex Condition from the Provider or facility;
   - Is undergoing a course of Institutional or Inpatient care from the Provider or facility;
   - Is scheduled to undergo nonelective Surgery from the Provider, including receipt of postoperative care from such Provider or facility with respect to such a Surgery;
   - Is pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; or
   - Is or was determined to be terminally ill and is receiving treatment for such illness from such Provider or facility.

   Serious and Complex Condition means:

   - In the case of an acute illness, a Condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
   - In the case of a chronic illness or Condition, a Condition that is:
     - Life-threatening, degenerative, potentially disabling, or congenital; and
     - Requires specialized medical care over a prolonged period of time.

c. The General Provision entitled, "Your Financial Responsibilities" is amended so as to revise the item listed for any charges, other than Emergency Medical Conditions, to read as follows:

Any charges, other than for services described in the "No Surprise Billing" section of this Benefit Book, received from Non-HMO/EPO Network Providers.

d. The General Provision entitled, "Your Financial Responsibilities" is amended so as to revise the item listed for Excess Charges to read as follows:

Excess Charges for services and supplies rendered by Non-HMO/EPO Network Providers, except as stated in the "No Surprise Billing" section of this Benefit Book.

e. The first paragraph of the General Provision entitled, "Prior Approval of Non-Network Benefits" is deleted and replaced with the following:

There may be certain services that you know in advance can only be obtained from a Non-HMO/EPO Network Provider. In order to protect you from balance billing and the increased out-of-pocket expense that could otherwise

occur for using a Non-HMO/EPO Network Provider, you must obtain approval in advance from Medical Mutual for services that cannot be provided by an HMO/EPO Network Provider. Upon Medical Mutual's approval of the Non-Network care, benefits for Covered Services will be provided as if the Covered Services were proved by an HMO/EPO Network Provider.

5. **COVID-19 Coverage**: The following coverage is in effect during the national public health emergency declared by the Department of Human Health Services ("HHS") on January 31, 2020 (effective January 27, 2020), or as required by applicable state or federal law, if any provisions of this section are extended beyond the emergency period.
   a. Coverage is provided for certain diagnostic and preventive services related to COVID-19 without cost-sharing requirements (including Deductibles, Copayments and Coinsurance), prior authorization or other medical management requirements.
   b. Actively-at-work or similar eligibility requirements may be relaxed for otherwise eligible Employees who are impacted by COVID-19 for certain situations, such as layoffs, furloughs, reduced hours or reduced pay.
   c. Limited extensions are provided for certain notification requirements relative to special enrollment, COBRA elections and filing of claims and appeals.
   d. To the extent state or federal law requires different benefits and/or coverage than described above, the Plan will be deemed to include those benefits and/or coverage.

IN WITNESS
WHEREOF:

Medical Mutual Services, LLC

Steven C. Glass
President & CEO

HEALTH CARE BENEFIT BOOK

This Benefit Book describes the health care benefits available to you as a Covered Person in the Self Funded Health Benefit Plan (the Plan) offered to you by your Employer or your Union (the Group). It is subject to the terms and conditions of the plan document. Please read through it carefully to understand your benefits.

THIS HMO PLAN SERVES COVERED PERSONS WHO WORK OR RESIDE IN THE SERVICE AREA SHOWN ON THE SCHEDULE OF BENEFITS.

YOU MUST UTILIZE HMO NETWORK PROVIDERS TO RECEIVE BENEFITS UNDER THIS PLAN, AS THERE IS NO COVERAGE UNDER THIS PLAN FOR NON-HMO NETWORK PROVIDERS, EXCEPT FOR EMERGENCY MEDICAL CONDITIONS.

A LIST OF HMO NETWORK PROVIDERS CAN BE FOUND AT OUR WEBSITE AT WWW.MEDMUTUAL.COM OR BY CALLING A CUSTOMER SERVICE REPRESENTATIVE AT THE PHONE NUMBER SHOWN ON YOUR I.D. CARD.

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 or included with a document prepared by your Group that is called a summary plan description.

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

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

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

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

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

SCHEDULE OF BENEFITS

To receive benefits, Covered Services must be provided by MedFlex HMO Network Providers, referred to throughout this Benefit Book as "HMO Network Providers," except for an Emergency Medical Condition. Additional information regarding Covered Services can be found in the "Health Care Benefits" section of this Benefit Book.

THIS HMO PLAN SERVICES COVERED PERSONS WHO RESIDE IN THE COUNTIES OF ALLEN, ASHLAND, ASHTABULA, AUGLAIZE, BROWN, BUTLER, CHAMPAIGN, CLARK, CLERMONT, COLUMBIANA, CUYAHOGA, DEFIANCE, DELAWARE, FAIRFIELD, FRANKLIN, FULTON, GEAUGA, GREENE, HAMILTON, HENRY, HURON, LAKE, LICKING, LORAIN, LUCAS, MADISON, MAHONING, MEDINA, MERCER, MIAMI, MONTGOMERY, PICKAWAY, PORTAGE, PUTNAM, SENECA, STARK, SUMMIT, TRUMBULL AND WOOD IN THE STATE OF OHIO. This is known as the "Service Area." Refer to the Eligibility section of this Certificate for additional information.

Remember, in an Emergency, always go to the nearest appropriate medical facility; we encourage you to notify your Primary Care Physician, if applicable, as soon as medically possible. To receive benefits, follow-up care must be provided by a HMO Network Provider.

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

HMO NETWORK MEDICAL BENEFIT	
Blood Deductible	Three pints
Deductible per Benefit Period	
If you have single coverage:	$5,000
If you have family coverage:	$10,000
Coinsurance Limit per Benefit Period	
If you have single coverage:	$0
If you have family coverage:	$0
Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	$7,500
If you have family coverage:	$15,000
Deductible and Out-of-Pocket Maximum Processing	Embedded (1)

Any Excess Charges you pay for claims will not accumulate toward any applicable Coinsurance Limit or toward the Out-of-Pocket Maximum.

BENEFIT MAXIMUMS PER COVERED PERSON	
(per Benefit Period unless otherwise shown)	
Autism Spectrum Disorders • Speech and Language Therapy • Occupational and Physical Therapy	 20 visits 40 visits (combined)
Chiropractic Visits	12 visits
Inpatient Physical Medicine and Rehabilitation	60 days
Outpatient Cardiac Rehabilitation Services	20 visits
Outpatient Occupational and Physical Therapy Services	40 visits (combined)
Outpatient Pulmonary Therapy Services	20 visits
Outpatient Speech Therapy Services	20 visits
Routine Mammogram Services	One mammogram; mammograms are limited to 130% of the Medicare reimbursement amount; the maximum reimbursement amount applies only to Covered Services received inside the state of Ohio, as mandated by the state of Ohio.
Routine Pap Test	One test
Skilled Nursing Facility Services	90 days

MAXIMUM BENEFIT PAYABLE FOR TRANSPLANT RELATED SERVICES (travel-related expenses)	
For the Covered Person's transportation, lodging and meal expenses related to the Covered Person's transplant	$10,000 per transplant

COINSURANCE AND COPAYMENTS FOR INSTITUTIONAL AND PROFESSIONAL CHARGES	
TYPE OF SERVICE	**For Covered Services received from an HMO Network Provider, You pay the following portion, based on the Allowed Amount**
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	$250 Copayment, waived if admitted, then 20%
Emergency Room Physician's Charges in an Emergency	20%
All other related Charges in an Emergency	20%
INPATIENT SERVICES	
Semi-Private Room and Board	20%
Physical Medicine and Rehabilitation	20%
Maternity	20%
Skilled Nursing Facility	20%
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 SERVICES	
Cardiac Rehabilitation Services	20%
Chiropractic Services	20%
Occupational Therapy Services	20%
Physical Therapy Services	20%
Respiratory Therapy Services	20%
Pulmonary Therapy Services	20%
Speech Therapy Services	20%
PHYSICIAN/OFFICE SERVICES	
Immunizations	20%
Medically Necessary Office Visits (2)(3)	$35 Copayment, not subject to the Deductible
Medically Necessary Office Visits in a Specialist's Office	$35 Copayment, not subject to the Deductible
Urgent Care Office Visits	$50 Copayment, not subject to the Deductible
ROUTINE, PREVENTIVE AND WELLNESS SERVICES	
Preventive Services in accordance with state and federal law (4)	0%, not subject to the Deductible
Colonoscopy and Sigmoidoscopy (Ages 40-75)	0%, not subject to the Deductible
Laboratory, X-ray and Medical Testing Services	20%
Mammograms	0%, not subject to the Deductible
Pap Tests	0%, not subject to the Deductible
Physical Examinations (Age 21 and over)	0%, not subject to the Deductible
Well Child Care Services (Under age 21)	0%, not subject to the Deductible

COINSURANCE AND COPAYMENTS FOR INSTITUTIONAL AND PROFESSIONAL CHARGES	
TYPE OF SERVICE	**For Covered Services received from an HMO Network Provider, You pay the following portion, based on the Allowed Amount**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.	
SURGICAL SERVICES	
Inpatient Surgery	20%
Medically Necessary Endoscopic Procedures (i.e, Colonoscopy, Sigmoidoscopy, etc.)	20%
Outpatient Surgery	20%
OTHER SERVICES	
All Other Covered Services	20%

Notes

Copayments - For some Covered Services, you will be responsible for paying a Copayment at the time services are rendered. Copayments are stated as a dollar amount and they are specified in this Schedule of Benefits. Copayments are not reimbursed by Medical Mutual. You will have to pay the Copayments each time you receive these Covered Services until your Out-of-Pocket Maximum has been met.

1. "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-Maximum will not exceed the Out-of-Pocket Maximum for single coverage shown on the Schedule of Benefits. For plan year 2019 the self-only Out-of-Pocket Maximum is $7,900.

   "Aggregate processing" - A family plan that has one Deductible and one Out-of-Pocket Maximum for everyone in the family. However, each Covered Person's Out-of-Maximum will not exceed the Out-of-Pocket Maximum applicable to self-only coverage permitted by the Affordable Care Act and its associated regulations. For plan year 2019 the self-only Out-of-Pocket Maximum is $7,900.

2. You may be charged more than one Copayment per visit if multiple types of examinations are performed.
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

To receive benefits, Prescription Drug Covered Services must be provided by Network Pharmacies or Contracting Home Delivery Pharmacies.

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 Out-of-Pocket Maximum shown in the Comprehensive Major Medical Schedule of Benefits. However, if a Brand Name Prescription Drug is purchased when a Generic Prescription Drug is available and medically appropriate (as determined by the Covered Person's Physician), the difference between the cost of the Generic and Brand Name Prescription Drug that the Covered Person pays is not counted toward the Out-of-Pocket Maximum.

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

Days Supply	30 days for retail Prescription Drugs 30 days for Specialty Prescription Drugs 90 days for Home Delivery Prescription Drugs

The following Prescription Drugs are subject to the Prescription Drug Copayment each time services are received:

- Prilosec Over-the-counter (1) and Omeprazole

RETAIL PHARMACY BENEFIT - UP TO A 30 DAYS SUPPLY	
TYPE OF SERVICE	**For Covered Services, you pay the following portion, based on the Allowed Amount**
Generic Prescription Drugs	30%, with a minimum Copayment of $10
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is not available or manufactured	30%, with a minimum Copayment of $35
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	30%, with a minimum Copayment of $35, plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is not available or manufactured	30%, with a minimum Copayment of $50
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	30%, with a minimum Copayment of $50, plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug
Prescribed Generic Prescription Drug Contraceptives or Brand Name Prescription Drug Contraceptives when an equivalent Generic Prescription Drug Contraceptive is not available	$0 Copayment, not subject to the Deductible
Preventive Prescription Drugs and Vaccines in accordance with state and federal law.	$0 Copayment, not subject to the Deductible
If your Prescription Order is for a Prescription Drug or supply that is available through the Home Delivery Prescription Drug program and you choose not to use the Home Delivery Prescription Drug program, you will be required to pay two times the appropriate Copayment shown in the Prescription Drug Schedule of Benefits when your Prescription Order is filled beyond the second time within a 180-day period.	

CONTRACTING HOME DELIVERY PHARMACY BENEFIT - 90 DAYS SUPPLY	
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	25%, with a minimum Copayment of $35
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is not available or manufactured	25%, with a minimum Copayment of $75
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	25%, with a minimum Copayment of $75, whichever is greater, plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is not available or manufactured	25%, with a minimum Copayment of $112.50
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	25%, with a minimum Copayment of $112.50, whichever is greater, plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug
Prescribed Generic Prescription Drug Contraceptives or Brand Name Prescription Drug Contraceptives when an equivalent Generic Prescription Drug Contraceptive is not available	$0 Copayment, not subject to the Deductible
Preventive Prescription Drugs and Vaccines in accordance with state and federal law.	$0 Copayment, 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.

SPECIALTY DRUG PHARMACY BENEFIT - UP TO A 30 DAY SUPPLY	
TYPE OF SERVICE	**For Covered Services received from a CONTRACTING Specialty Drug Pharmacy, you pay the following portion, based on the Allowed Amount**
Generic Prescription Drugs	30%, with a minimum Copayment of $10, or the maximum of any available manufacturer-funded Copay assistance (2)
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is not available or manufactured	30%, with a minimum Copayment of $35, or the maximum of any available manufacturer-funded Copay assistance (2)
Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	30%, with a minimum Copayment of $35, plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug, or the maximum of any available manufacturer-funded Copay assistance (2)
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is not available or manufactured	30%, with a minimum Copayment of $50, or the maximum of any available manufacturer-funded Copay assistance (2)
Non-Preferred Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	30%, with a minimum Copayment of $50, plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug, or the maximum of any available manufacturer-funded Copay assistance (2)

Prescription Drug Notes

1. Over-the-counter supplies drugs require a Prescription Drug Order.

2. This Plan includes a Specialty Prescription Drug Copay offset program ("Program"). By participating in the Program, the Covered Person's Prescription Drug Copays for Specialty Prescription Drugs may be set to the maximum of the current Plan design, or to the amount of any available manufacturer-funded Copay assistance, but the drug manufacturer will absorb most, or all, of this amount. As with other patient assistance programs, any financial assistance the Covered Person receives toward his or her cost of the drug does not apply toward the Covered Person's Out-of-pocket Maximum. **If the Covered Person chooses not to participate in the Program, he or she will be responsible for paying a significantly higher Prescription Drug Copay for that particular drug.**
3. Please contact Customer Care to find out what Specialty Prescription Drugs are part of this Program. The list is also available on 'My Health Plan,' Medical Mutual's secure member website.

HOW TO USE YOUR BENEFIT BOOK

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

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

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

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

The **Health Care Benefits** section explains your benefits and some of the limitations on the Covered Services available to you. **You cannot, except as stated in this Benefit Book, receive benefits without utilizing a HMO Network Provider.** However, Preauthorization of a treatment, or course of treatments, does not imply an approval for payment of benefits for treatment(s) in excess of your level of benefits.

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 receive benefits. 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.

For further information about this coverage, including how health care services can be obtained, contact our customer service representatives at the toll-free telephone number shown on your identification card.

DEFINITIONS

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

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

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 - The Allowed Amount, including for Pharmacies, is the lesser of the applicable Negotiated Amount or the Covered Charge.

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.

Basic Health Care Services - according to Chapter 1751.01 of the Ohio Revised Code, the following Covered Services are considered Basic Health Care Services:

- Physician's services
- Inpatient Hospital services
- Outpatient medical services
- Emergency health services
- Urgent Care services
- Diagnostic laboratory services
- Diagnostic and therapeutic radiologic services
- Diagnostic and treatment services for Mental Illness, other than Prescription Drug Services
- Preventive health services, including, but not limited to:
  - Voluntary family planning services
  - Infertility services
  - Periodic physical examinations
  - Pre-natal obstetrical care
  - Well child care
- Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code. "Basic health care services" does not include experimental or investigational procedures.

Benefit Book - this document.

Benefit Period - the period of time specified in the Schedule of Benefits during which Covered Services are rendered, and benefit maximums, Deductibles, Coinsurance Limits and 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."

Card Holder - an eligible person who has enrolled for coverage under the terms and conditions of the Plan and whose name appears on the identification card.

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 for which you are responsible after you have met your Deductible or paid your Copayment, if applicable.

Coinsurance Limit - a specified dollar amount of Coinsurance expense Incurred in a Benefit Period by a Covered Person for Covered Services.

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

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

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 received from a Medical Mutual HMO Network Provider.

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

Covered Service - a Provider's service or supply as described in this Benefit Book for which the Plan 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 the Plan will start to provide benefits.

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, including any trauma and burn center of the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

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

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. Refer to the Schedule of Benefits and the Health Care Benefits section of this Benefit Book to identify which of these Essential Health Benefits are included in this plan.

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

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, the Plan will cover those Medically Necessary services associated with the Experimental or Investigational drug, device, or portion of a medical treatment or procedure that the Plan 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 the Group and Medical Mutual in their 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.

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.

Group - the employer or organization who enters into an Agreement with Medical Mutual for Medical Mutual to provide administrative services for such employer's or organization's health plan.

HMO Network Provider - a Provider that is included in a limited panel of Providers as designated by Medical Mutual. This limited panel of Providers is otherwise known as a health maintenance organization (HMO). Providers in this HMO Network have an agreement with Medical Mutual about payment for Covered Services.

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

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

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

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

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

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

Non-HMO Network Provider - a Provider that does not meet the definition of a HMO 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 that require compensation from their patients. Other than incidentally, these facilities are not used as offices or clinics for the private practice of a Physician or Other Professional Provider. The Plan will only provide benefits for services or supplies for that a charge is made. Only the following Institutions that 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 that provides nursing and other services as specified in the Home Health Care Services section of this Benefit Book. A Home Health Care Agency is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Hospice Facility -** a facility that provides supportive care for patients with a reduced life expectancy due to advanced illness as specified in the Hospice Services section of this Benefit Book.
- **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 - only the following persons or entities which are licensed as required:

- advanced nurse practitioner (A.N.P.);
- ambulance services;
- certified dietician;
- 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);
- nurse-midwife;
- 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, including any applicable Prescription Drug Deductibles, Coinsurance and Copayments, 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.

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

PPACA - Patient Protection and Affordable Care Act

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. Preauthorization is not a promise that the Plan will cover the cost.

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 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.

Prescription Fill - for the purposes of cancer oral chemotherapy, this means up to a 30-day supply of a Prescription Drug.

Primary Care Physician - a Physician or group of Physicians, advanced nurse practitioners trained in family or general practice, geriatrics, internal medicine, obstetrics/gynecology or neonatology/pediatric medicine who has a contractual

obligation with Medical Mutual to provide the primary care services of this plan and who may request Medical Mutual to authorize Covered Services from Non-Network Providers.

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.

Service Area - Certain counties within the State of Ohio, as described in the Schedule of Benefits.

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 Benefit Book.

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

Urgent Care - 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

Enrolling for Coverage

Prior to receiving this Benefit Book, you enrolled, and were accepted or approved by your Group for individual coverage or family coverage. For either coverage, you may have completed an Enrollment Form. There may be occasions when the information on the Enrollment Form is not enough. The Group will then request the additional data needed to determine whether your dependents are Eligible Dependents. Coverage will not begin until your enrollment has been approved and you have been given an effective date.

Under individual coverage, only the Card Holder is covered. Under family coverage, the Card Holder and the Eligible Dependents who have been enrolled are covered. You must work or reside in the Service Area of Medical Mutual to be a Card Holder.

Eligible Employees

An Eligible Employee is:

An employee of the Group who meets the eligibility requirements of the Group including working the required number of hours that the Group requires for eligibility. Any applicable waiting period must be satisfied, but 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 Card Holder's spouse, provided you are not legally separated;
- the Card Holder's or spouse's:
  - natural children;
  - children placed for adoption and legally adopted children;
  - children for whom either the Card Holder or Card Holder's spouse is the Legal Guardian or Custodian; or
  - any children who, by court order, must be provided health care coverage by the Card Holder or Card Holder's spouse; or
- the Card Holder's stepchildren, provided the natural parent remains married to the Card Holder and resides in the household.

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

Eligibility will continue past the age limit for Eligible Dependents who are unmarried and primarily dependent upon the Card 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 your Group of the Eligible Dependent's desire to continue coverage within 31 days of reaching the limiting age. After a two-year period following the date the Eligible Dependent meets the age limit, the Plan 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 Card 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 Card 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 Card 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 Card Holder. In addition, should the Card 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 you or your spouse acquire an Eligible Dependent. You must notify your Group benefits administrator who must then notify Medical Mutual of the change.

Coverage for a spouse and other Eligible Dependents who become eligible by reason of marriage will be effective on the date of the marriage if a request for their coverage is submitted to the Group within 31 days of marriage.

A newborn child or an adopted child will be covered as of the date of birth or adoptive placement, provided that you request enrollment within 31 days of the date of birth or adoptive placement. Coverage will continue for an adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

It is important to complete and submit your Enrollment Form promptly, because the date this new coverage begins will depend on when you request enrollment.

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

Special Enrollment

You or your Eligible Dependent who has declined the coverage provided by this Benefit Book may enroll for coverage under this Benefit Book 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 Benefit Book 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 legal separation or divorce
    b. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Benefit Book)
    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 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 contain the Card Holder's name, identification number and a toll-free telephone number that provides you with access to health care and information as to how health care may be obtained, 24 hours per day, 7 days per week. Another telephone number on your card is a toll-free Customer Service number which, during normal business hours, provides you with access to information on the coverage available to you under your health plan and information on Medical Mutual's internal and external review processes. The identification card should be presented when receiving Covered Services under this coverage because it contains information you or your Provider will need when making an inquiry. Your receipt or possession of an identification card does not mean that you are automatically entitled to benefits.

Your identification card is the property of Medical Mutual. After coverage ends, use of the identification card is not permitted and may subject you to legal action.

HEALTH CARE BENEFITS

THIS HMO PLAN SERVES COVERED PERSONS WHO RESIDE IN THE SERVICE AREA SHOWN ON THE SCHEDULE OF BENEFITS.

YOU MUST UTILIZE HMO NETWORK PROVIDERS TO RECEIVE BENEFITS UNDER THIS PLAN, AS THERE IS NO COVERAGE UNDER THIS PLAN FOR NON-HMO NETWORK PROVIDERS, EXCEPT FOR EMERGENCY MEDICAL CONDITIONS.

Inpatient and Outpatient Medical Care at a children's Hospital Inpatient or Outpatient facility is limited to children under the age of twenty (20), except in the event of an Emergency Medical Condition, or upon the determination that Medical Care from a children's Hospital Inpatient or Outpatient Provider is Medically Necessary.

Medical Mutual will furnish you with a list of HMO Network Providers upon enrollment and/or request. In the event Medical Mutual's contract with a particular Primary Care Physician or Hospital ends, resulting in that Physician or Hospital becoming a Non-HMO Network Provider, Medical Mutual will notify you if either or both of the following apply:

- you received health care services from that Primary Care Physician or Hospital within the 12-month period before that Provider's contract ended;
- you selected that Provider as your Primary Care Physician within the 12-month period before that Provider's contract ended.

In the above instances, you will be notified within 30 days following the date the Provider becomes a Non-HMO Network Provider. In addition, Medical Mutual will pay, in accordance with the terms of the Group Contract, for all Covered Services provided to a Covered Person by the Primary Care Physician or Hospital between the date of the termination of the contract and 5 days after notifying you of the contract termination.

All Covered Services must be Medically Necessary, unless otherwise specified. Medical Necessity is determined by Medical Mutual.

All Covered Services are subject to the limitations and exclusions stated in this Benefit Book and Schedule of Benefits. The amount you must pay is shown in the Schedule of Benefits.

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.

Alcoholism and Drug Abuse Services

Benefits are provided for the treatment of Alcoholism and Drug Abuse. 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 Benefit Book. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient receiving treatment for Alcoholism or Drug Abuse.

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. Network 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.

Allergy Tests and Treatments

Allergy tests and treatment that are performed and related to a specific diagnosis are Covered Services.

Ambulance Services

Transportation for conditions other than Emergency Medical Conditions via ambulance must be certified by your Primary Care Physician or HMO Network Provider. 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.

Transportation services provided by an ambulette or a wheelchair van are 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 Benefit Book may be approved. All case management programs are voluntary for the patient.

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

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

Clinical Trial Programs

Benefits are provided for Routine Patient 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:

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 HMO 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.

"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 Plan 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 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 an Accidental Injury

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

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.

Diagnostic Services

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

- radiology, ultrasound and nuclear medicine;
- laboratory and pathology services; and
- EKG, EEG, MRI and other electronic diagnostic medical procedures.

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 the treatment of an Emergency Medical Condition on a seven-days-per-week, 24 hours per-day basis, received both inside and outside the Service Area. Coverage for an Emergency Medical Condition will be provided in accordance with the Schedule of Benefits.

In the event of an Emergency:

- call 911 or go to the nearest Hospital; and
- notify your Primary Care Physician within 24 hours or as soon as medically possible to request authorization for your treatment.

If, in any instance, whether inside or outside the Service Area, it is necessary for you to be admitted to a Hospital as an Inpatient, you must receive prior authorization from Medical Mutual, if medically possible. If Medical Mutual requires your transfer to a HMO Provider, your transportation expenses are covered in full. The sooner Medical Mutual is notified about your Condition, the sooner Medical Mutual can become involved with your care and relay vital information to the attending Physician.

Follow-up care is care received subsequent to the initial visit for an Emergency Medical Condition. **If medically possible, you must contact Medical Mutual prior to obtaining follow-up care.**

Visits to the emergency room of a Hospital - Refer to the Schedule of Benefits for any amounts you must pay each time you receive services at the emergency room of a Hospital. If you are admitted to a Hospital as an Inpatient, any Copayment required will be waived.

We encourage you to notify your Primary Care Physician, if applicable, within 24 hours, or as soon as medically possible. These policies also apply to medical treatment received as the result of a 911 call response. If you receive treatment for an Emergency Medical Condition from a Non-HMO Network Provider, Medical Mutual will pay for Covered Services at the HMO Network Provider level of benefits. Please bear in mind that services from Non-HMO Network Providers are covered only for Emergency Medical Conditions, or if you have received prior approval from Medical Mutual to obtain a Covered Service unavailable from an HMO Network Provider.

Gender Dysphoria Treatment

Medical Mutual will cover Medically Necessary services for the treatment of gender dysphoria, subject to accepted medical clinical guidelines and corporate medical policies.

Health Education Services

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.

Home Health Care Services

The following are Covered Services when you receive them from a Hospital or a Home Health Care Agency:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- Prescription Drugs;
- oxygen and its administration;
- medical social services, such as the counseling of patients; and
- home health aide visits when you are also receiving covered nursing or therapy services.

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

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

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

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:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- Prescription Drugs; limited to a two-week supply per Prescription Drug Order or refill (These Prescription Drugs must be required in order to relieve the symptoms of a Condition, or to provide supportive care.);
- 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;
- durable medical equipment; 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 Hospital Services

The course of treatment which is recommended must be authorized in advance by Medical Mutual. The Covered Services listed below are benefits when services are performed in an Inpatient setting, except as specified.

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

- a semiprivate room or ward;
- a private room, when Medically Necessary; if you request a private room, the Plan 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. The Plan will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded.
- 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 and 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. Network 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. If your Inpatient stay is for an organ transplant, please review the requirements under the Organ Transplant Services section.

Inpatient Physical Medicine and Rehabilitation Services

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

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 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-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 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: the Plan will cover Maternity Services as described in this Benefit Book 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 Benefit Book. 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 Benefit Book 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 a Network Physician or your Primary Care 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 enrolling for family coverage.

Office Visits - Office visits, including After Hours Care 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.

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:

- syringes
- needles
- oxygen
- diabetic 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, the Plan will not cover more in total rental costs than the customary purchase price as determined by Medical Mutual. For example, if you submit claims for the monthly rental fee and by the third month the total in rental dollars meets or exceeds the customary purchase price, you will have exhausted your benefit for that piece of Durable Medical Equipment.

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

Covered DME includes:

- blood glucose monitors;
- respirators;
- home dialysis equipment;
- wheelchairs;
- hospital beds;
- crutches; and
- mastectomy bras.

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;**
  - **other compression devices.**

Orthotic Devices - Rigid or semirigid supportive devices which limit or stop the motion of a weak or diseased body part are covered. These devices include:

- braces for the leg, arm, neck or back;
- trusses; and
- back and special surgical corsets.

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

- **garter belts, arch supports, corsets and corn and bunion pads;**
- **corrective shoes, except with accompanying orthopedic braces; and**
- **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:

- intraocular lens implantation for the treatment of cataract, aphakia or keratoconus;
- soft lenses or sclera shells for use as corneal bandages when needed as a result of eye Surgery;
- artificial hands, arms, feet, legs and eyes, including permanent lenses; and
- appliances needed to effectively use artificial limbs or corrective braces; and
- mastectomy prosthetics.

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;**
- **replacement of cataract lenses unless needed because of a lens prescription change;**
- **taxes included in the purchase of a covered prosthetic appliance;**
- **deluxe prosthetics that are specially designed for uses such as sporting events; and**
- **wigs and hair pieces.**

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 Benefit Book. 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 autism and intellectual disability, other than those necessary to evaluate or diagnose these Conditions, are not covered. Services for the treatment of attention deficit disorder are 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. Network 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.

Organ Transplant Services

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

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

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

Organ Transplant Preauthorization - In order for an organ transplant to be a Covered Service the Inpatient stay and the proposed course of treatment must be approved by Medical Mutual. HMO Network Providers are responsible for obtaining this prior approval from Medical Mutual.

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.

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

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

Donor Benefits - Benefits necessary for obtaining an organ 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 - Depending upon the circumstances involved, the Plan may cover reasonable and necessary travel and lodging expenses for the transplant recipient, subject to any limitations set forth in the Schedule of Benefits.

The Plan does not provide organ 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;**
- **for travel time and the travel-related expenses of a Provider;**
- **that are related to other than human organ.**

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, unless otherwise specified.

Covered Institutional services include, but are not limited to:

- operating, delivery and treatment rooms and equipment;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. The Plan will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded.
- 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 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. Therapy services must be ordered by a Physician or Other Professional Provider to be covered. Covered Services are limited to the therapy services listed below:

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

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

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 medical Condition such as:

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

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.**

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.

The Plan 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 Pharmacies and are limited to a maximum of a thirty (30) day supply. Specialty Prescription Drugs require prior approval from Medical Mutual.

This Plan includes a Specialty Prescription Drug Copay offset program ("Program"). By participating in the Program, the Covered Person's Prescription Drug Copays for Specialty Prescription Drugs may be set to the maximum of the current Plan design, or to the amount of any available manufacturer-funded Copay assistance, but the drug manufacturer will absorb most, or all, of this amount. As with other patient assistance programs, any financial assistance the Covered Person receives toward his or her cost of the drug does not apply toward the Covered Person's Out-of-pocket Maximum. **If the Covered Person chooses not to participate in the Program, he or she will be responsible for paying a significantly higher Prescription Drug Copay for that particular drug.**

Using the Formulary: 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 through the coverage review process. An exception may be granted by Medical Mutual if the Formulary alternative drug has been ineffective in the treatment of the Covered Person's disease or Condition, or the Formulary alternative drug causes, or is reasonably expected to cause a harmful or adverse reaction in the Covered Person.

If you do not present your identification card to the Pharmacy when you obtain Prescription Drugs, the Pharmacy may require you to pay the full cost of the Prescription Drug, and you will need to submit a claim to Medical Mutual for reimbursement.

Medical Mutual may, in its sole discretion, limit coverage for Prescription Drugs to certain ages or quantities. Covered Services will be limited based upon Medical Necessity; 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.

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 Copayment, Coinsurance or Deductible amounts specified in the Schedule of Benefits. The requirement to pay the applicable cost sharing (Deductible, Copays 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, Copays, 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.

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
- 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 a Generic Prescription Drug or Preferred Brand Name Drug substitute is 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. 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 reimbursed for the difference in cost between the Generic and Brand Name Prescription Drugs for the most recent prescription. To obtain more information regarding this process, please contact a customer service representative by calling the number listed on your ID card.

When Prescription Drugs are approved by the Food and Drug Administration ("FDA"), they will not be covered until Medical Mutual establishes criteria for Medically Necessary prescriptions. This criteria may be established at approximately six months of the FDA approval. Some Prescription Drugs approved by the FDA may never qualify as Medically Necessary.

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, if applicable, provided by Medical Mutual.

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 Benefit Book)

Coverage is not provided for:

1. Drugs not covered on the Formulary, except as described in the Prescription Drug Services benefit.
2. Drugs received from a non-Network Pharmacy or a non-Contracting Home Delivery Pharmacy.
3. Drugs dispensed for cosmetic purposes or used solely for beautifying or altering one's appearance in the absence of any underlying Condition.
4. Therapeutic devices.
5. Artificial appliances.
6. Lost, stolen or damaged Prescriptions.
7. Prescription Drugs that have been determined by Medical Mutual to be abused or otherwise misused.
8. More than the number of Prescription Drug refills specified by the Prescriber.
9. Any refill of a Prescription Drug dispensed after the length of time allowed by laws.
10. Charges for more than the days supply of a Prescription Drug, as specified in the Prescription Drug Schedule of Benefits.
11. Incurred or received after you stop being a Covered Person.
12. Fees for administering or injecting Prescription Drugs, except for vaccines covered under PPACA.
13. Compound medications in which the active ingredients do not require a Prescription Order or are not determined to be Medically Necessary.
14. Allergy sera.
15. Over-the-counter items and drugs, unless required by law.
16. Anabolic steroids.
17. Diagnostic, imaging and test agents and devices except for those used for blood glucose testing, or diabetes.
18. Drugs for the treatment of acne (e.g., Retin Atretinoin) for Covered Persons over age 35 years.
19. Any blood and blood plasma products.
20. Prescription Drugs that have an over-the-counter equivalent available.

21. For proton pump inhibitors, except as specified.
22. Weight loss drugs except as may be required by PPACA.
23. Enteral or parenteral therapy, medical food, nutritional or dietary supplements or supplies.
24. Infant formula
25. For lifestyle improvement drugs, if Medical Mutual, in it's sole discretion, deems the only clinical results for such drugs to not be necessary for the cure or prevention of disease, illness or injury, unless required by PPACA.
26. For drugs not approved by the FDA.
27. Disposable insulin needles and syringes which are not prescribed by a Prescriber.
28. Drug used to decrease or increase weight gain or appetite control, or to treat obesity.
29. Homeopathic drugs in any dosage form.
30. Minerals and vitamins, unless required by PPACA.
31. Prescription Drugs used to treat dental conditions, including, but not limited to, the treatment of gingivitis.
32. Refilled prescriptions if less than 75% of the original prescriptions (or subsequent refill) has been used.

Preventive and Wellness Services

PPACA and Ohio Preventive Services

Gynecological Services -

- mammogram services; and
- PAP tests.

Health Education Services -

- 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.

Immunizations - Immunizations are covered.

Physical Examinations - Physical examinations are covered.

Other Services - The following services are covered:

- blood glucose screenings, screening for type 2 diabetes limited to asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm/Hg
- bone density screenings, limited to women ages 50 and older
- chlamydia screenings, limited to pregnant and sexually active women age 24 and younger and for older women who are at an increased risk
- cholesterol screenings, limited to:
  - men ages 35 and older for lipid disorders
  - men ages 20 to 35 for lipid disorders if they are at an increased risk for coronary heart disease
  - women ages 20 and older for lipid disorders if they are at an increased risk for coronary heart disease
- colorectal cancer screenings; using fecal occult blood testing, sigmoidoscopy or colonoscopy in adults beginning at age 40 and continuing until age 75
- hepatitis B virus screenings; limited to pregnant women in their first prenatal visit.

Voluntary Family Planning Services - The following services are covered:

- family planning counseling; and
- information on birth control.

Well Child Care Services - Coverage for well child care services will be provided for Covered Persons under the age of 21. Coverage for immunizations is also provided for Covered Persons under the age of 21.

Well child care services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination, routine newborn hearing screening and

developmental assessment. Vision tests, hearing tests and the developmental assessment must be included as part of the physical examination in order to be provided as part of this benefit. This review also includes anticipatory guidance, laboratory tests and appropriate immunizations.

Women's preventive services, in accordance with the age and frequency requirements of the Affordable Care Act, including, but not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; and counseling for contraceptive methods, breastfeeding and domestic violence.

Coverage is provided for FDA-approved contraceptive methods and counseling.

Additional Preventive Services

If not shown above as a Covered Service, the following services will also be covered without regard to any Deductible, Copayment or Coinsurance requirement that would otherwise apply:

- 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.

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/center/regulations/prevention.html. 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.

Additional Preventive and Wellness Services

The following services are covered:

- laboratory;
- x-rays;
- medical testing.

Private Duty Nursing Services

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

Private duty nursing services include services that Medical Mutual decides are of such a degree of complexity that the Provider's regular nursing staff cannot perform them. When private duty nursing services must be received in your home, nurse's notes must be sent in with your claim.

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

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

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 authorized 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.**

Smoking Cessation Services

For Covered Persons age 18 and over, benefits are provided for the screening of tobacco use and for smoking cessation programs for those Covered Persons using tobacco.

Surgical Services

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

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

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

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 as 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

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.

If it is necessary for you to be admitted to a Hospital as an Inpatient, you must receive prior authorization from Medical Mutual, if medically possible.

Remember, unless the Condition is an Emergency Medical Condition, no benefits are provided for treatment received from Non-HMO Network Providers.

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 HMO Network Provider, except for an Emergency Medical Condition, or as specified.
5. Received from other than a Provider.
6. Inpatient and Outpatient Medical Care at children's Hospital facilities for Covered Persons age twenty (20) and above, except in the event of an Emergency Medical Condition, or upon the determination that Medical Care from a children's Hospital Inpatient or Outpatient Provider is Medically Necessary.
7. For Experimental or Investigational drugs, devices, medical treatments or procedures, except as specified.
8. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
9. For a Condition that occurs as a result of any act of war, declared or undeclared.
10. For a Condition resulting from direct participation in a riot, civil disobedience, nuclear explosion or nuclear accident.
11. For which you have no legal obligation to pay in the absence of this or like coverage.
12. 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.
13. Received from a member of your Immediate Family.
14. Incurred after you stop being a Covered Person except as specified in the Benefits After Termination of Coverage section.
15. 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.
16. For X-ray examinations with no preserved film image or digital record.
17. 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.
18. 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 Benefit Book 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.
19. Received in a military facility for a military service related Condition.
20. For court-ordered testing or care unless Medically Necessary.
21. 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 Surgery), except as specified. This exclusion does not apply to medical complications directly related to such Surgery or other services.
22. For Surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment.
23. For weight loss Surgery and any repairs, revisions or modifications of such Surgery, including weight loss device removal, unless determined by Medical Mutual to be a Covered Service in accordance with Medical Mutual's corporate

medical policy. This exclusion does not apply to medical complications directly related to such Surgery or other services.

24. For treatment of Conditions related to autism and other pervasive developmental disorders, intellectual disabilities, or behavioral problems.
25. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss or obesity, unless otherwise specified.
26. For dietary and/or nutritional counseling or training, except as specified or required by PPACA.
27. For nutritional supplements.
28. For Outpatient educational, vocational or training purposes, except as otherwise specified or as may be required by PPACA.
29. For marital counseling.
30. For the medical treatment of sexual problems not caused by a biological Condition.
31. For male Contraceptives and over-the-counter birth control without a prescription.
32. For reverse sterilization.
33. For elective abortions.
34. For treatment of infertility, including, but not limited to, artificial insemination, in vitro fertilization, Gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT).
35. For dental implants, considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic, except as described in the "Dental Services for an Accidental Injury" benefit.
36. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery.
37. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
38. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.
39. For personal hygiene and convenience items.
40. For eyeglasses or contact lenses, except as described in the section entitled "Prosthetic Appliances" under the "Medical Supplies and Durable Medical Equipment" benefit.
41. 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), unless otherwise specified.
42. For hearing aids.
43. For massotherapy or massage therapy.
44. For hypnosis and acupuncture.
45. For blood which is available without charge. For Outpatient blood storage services.
46. For over the counter drugs, vitamins or herbal remedies, except for certain preventive drugs written with a Physician's prescription and required by PPACA.
47. For the Institutional charges and Physician charges related to non-emergency use of an emergency room.
48. 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.
49. For specialized camps.
50. For water aerobics.
51. For missed appointments, completion of claim forms or copies of medical records.
52. 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 Benefit Book.
53. For stand-by charges of a Physician.
54. For any Charges not documented in Provider records.
55. For fraudulent or misrepresented claims.
56. For charges for doing research with Providers not directly responsible for your care.
57. For non-Covered Services or services specifically excluded in the text of this Benefit Book.

GENERAL PROVISIONS

How to Apply for Benefits

You must pay any required Copayments, Deductibles or Coinsurance as shown in the Schedule of Benefits. You must present your identification card any time services are requested.

Notice of Claim; Claim Forms

A claim must be filed for you to receive benefits. HMO Network Providers and many Non-HMO Network Providers will submit a claim for you; if in the event you need to submit a claim from a Non-HMO Network Provider or for a Prescription Drug claim, 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 on behalf of the Plan unless written or electronically submitted proof that Covered Services have been given to you is received. Proof must be given within 90 days of your receiving Covered Services or as soon as is reasonably possible. 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 Benefit Book, you or your authorized representative, as appropriate, shall be notified of the failure and the proper procedures as soon as possible, but not later than five (5) days following the original receipt of the request. We may notify you orally unless you provide us with a written request to be notified in writing. Notification under this section is only required if both (1) the claim communication is received by the person or department customarily responsible for handling benefit matters and (2) the claim communication names a specific claimant, a specific medical Condition and a specific treatment, service or product for which approval is requested.

How Claims are Paid

You may be required to share in the cost of Covered Services. The Schedule of Benefits shows your financial responsibility for Covered Services.

Medical Mutual provides benefits for Covered Services through agreements with Network Providers based on the Allowed Amount.

Your Financial Responsibilities

You are responsible for:

- Any charges, other than for an Emergency Medical Condition, received from Non-Network Providers. (This does not apply if the service is not available from a HMO Network Provider, and prior approval has been obtained from Medical Mutual. See the provision entitled "Prior Approval of Non-Network Benefits.")

- 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.
- Billed Charges for services that are not Medically Necessary.
- Incidental charges.

All limits and Coinsurance applied to a specific diagnosed Condition include all services related to that Condition. If a specific service has a maximum, that service will also be accumulated to all other applicable maximums.

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 that is shown in the Schedule of Benefits as the Deductible, if applicable, before the Plan will begin to provide benefits. This is the amount of expense that must be Incurred and paid by you for Covered Services before the Plan starts to provide benefits. If a benefit is subject to a Deductible, only expenses for Covered Services under that benefit will satisfy the Deductible. To satisfy your Deductible, 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.

For Covered Charges Incurred during the last three months of the Benefit Period, any amount applied to your Deductible will also apply to the Deductible for the next Benefit Period.

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 Card 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.

Copayments

If a Covered Service is subject to a Copayment, you must pay the dollar amount specified in the Schedule of Benefits as the Copayment.

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 Benefit Book. 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.).

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 Benefit Book have maximums.

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

Provider Status and Direction of Payment

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

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

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 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 Network Providers.

Medical Mutual is authorized to make payments directly to Providers who have performed Covered Services for you. Medical Mutual also reserves the right in some circumstances to make payment directly to you in the event you receive Covered Services from a Non-HMO Network Provider. When this occurs, you must pay the Provider the amounts you may owe to the Provider. 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 non-covered 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 from the Provider on the behalf of the Group, and you must pay the Billed Charges amount to the Provider when requested.

Prior Approval of Non-Network Benefits

There may be certain services that can only be obtained from a Non-HMO Network Provider. In order to protect you from balance billing and the increased out-of-pocket expense that could otherwise occur for using a Non-HMO Network Provider, you must obtain approval in advance from Medical Mutual for services that cannot be provided by a HMO Network Provider. Upon Medical Mutual's approval of the Non-Network care, benefits for Covered Services will be provided as if the Covered Services were provided by a HMO Network Provider.

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

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

Medical Mutual will determine whether the Covered Services can be provided by a HMO 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 related physical exams required. You and your Physician will be notified if Covered Services provided by a Non-HMO Network Provider will be covered as if they had been provided by a HMO Network Provider. If you do not receive written approval in advance of receiving services from a Non-HMO Network Provider, no benefits will be provided, except for an Emergency Medical Condition.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from us or any other person (including a Primary Care Physician) to obtain access to obstetrical or gynecological care from a health care professional in our Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Medical Mutual at the phone number shown on your ID card or at medmutual.com.

Selection of a Primary Care Physician

We may require the designation of a Primary Care Physician. You have the right to designate any Primary Care Physician who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the Primary Care Physician. For information on how to select a Primary Care Physician, and

for a list of the participating Primary Care Physicians, contact Medical Mutual at the phone number shown on your ID card or at medmutual.com.

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 Benefit Book 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 Benefit Book. If you travel to a foreign country and you receive treatment for an Emergency Medical Condition from a Non-HMO Network Provider, Medical Mutual will provide coverage at the same level of benefits as a HMO Network Provider.

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 HMO Network Provider's staff or similar causes, or health care services provided under this Benefit Book are delayed or considered impractical. Under such circumstances, Medical Mutual and HMO Network Providers will provide the health care services covered by this Benefit Book as far as is practical under the circumstances, and according to their best judgment. However, Medical Mutual and HMO 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 Card Holder should have the following information available:

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

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

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

If you are not satisfied with the results, you may continue to pursue the matter through the appeal process.

Benefit Determination for Claims

Claims Involving Urgent Care

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

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

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

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

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

Concurrent Care Claims

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

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

Pre-Service Claims

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

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

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

Post-Service Claims

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

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

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

Adverse Benefit Determination Notices

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

- the specific reason(s) for the adverse benefit determination;
- reference to the specific plan provision(s) on which the adverse benefit determination is based;
- sufficient information to identify the claim or health care service involved, including the date of services, the health care provider, and the claim amount, if applicable;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of 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 the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
- a statement of your right to bring a civil action under federal law following an adverse benefit determination on review, if your Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA);
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the adverse benefit determination was based on Medical Necessity, Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

Please note: The processes described here are based on the claims and appeals processes set forth in the Patient Protection and Affordable Care Act and related regulations and guidance. As those regulations and guidance are subject to change, the claims and appeals processes for this plan are subject to change. The rules and/or procedures set forth in the most current claims and appeals regulations and guidance at the time your claim or appeal is processed will govern your claims and appeals, even if they conflict with the claims and appeals processes set forth herein.

Filing an Appeal

If you are not satisfied with any of the following:

- a benefit determination;
- a Medical Necessity determination;
- a determination of your eligibility to participate in the plan or health insurance coverage; or
- a decision to rescind your coverage (a rescission does not include a retroactive cancellation for failure to timely pay required premiums)

then you may file an appeal.

To submit an appeal electronically, go to Medical Mutual's Web site, www.MedMutual.com, under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card for more information about how to file an appeal. You may also write a letter with the following information: Card Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, 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, a healthcare professional with knowledge of your medical condition may act as your Authorized Representative without a signed and dated statement from you.

Mandatory Internal Appeal

The Plan offers you a mandatory internal appeal.You must complete this mandatory internal appeal 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 in the Filing an Appeal section above.

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law for this plan. The internal appeal process is a review of your appeal by an appeals specialist, a Physician consultant and/or other licensed 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 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 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.

The appeal procedures are as follows:

Appeal of a Claim Involving Urgent Care

- You, your authorized representative or your Provider may request an appeal of a Claim Involving Urgent care. The appeal does not need to be submitted in writing. 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 could affect the ability of the patient to regain maximum functions, or (2) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.The appeal must be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request to appeal. The expedited appeal process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action. When you request an internal appeal for an urgent care claim, at the same time you may also file a request for an expedited external review as described below.

Pre-Service Claim Appeal

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

Post-Service Claim Appeal

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

All notices of a Final adverse benefit determination after an appeal will be culturally and linguistically appropriate and will include the following:

- the specific reason(s) for the adverse benefit determination;
- reference to the specific plan provision(s) on which the adverse benefit determination is based;
- sufficient information to identify the claim or health care service involved, including the date of services,the health care provider, and the claim amount (if applicable);
- statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- if the adverse benefit determination was based on a Medical Necessity, Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request;
- a discussion of the decision;
- a description of applicable appeal procedures; and
- a statement of your right to bring a civil action under federal law following an adverse benefit determination on review, if your Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

If your claim is denied at the internal mandatory appeal level, then depending on the type of plan you have and the type of claim, there are two different voluntary review options available. You will be eligible for EITHER the External Review Process OR the Voluntary Internal Review Process. These two processes, and the eligibility requirements, are described below.

External Review Process

Medical Mutual has established an external review process to examine coverage decisions under certain circumstances. The request for External Review must be made within four months from your receipt of the notice of denial from the internal mandatory appeal. You may be eligible to have a decision reviewed through the external review process if you meet the following criteria:

1. The adverse benefit determination involves medical judgment, as determined by the external reviewer, or a rescission of coverage;
2. You have exhausted the mandatory internal appeal process unless under applicable law you are not required to exhaust the internal appeal process (for example, when your claim is entitled to expedited external review or, if you do not receive a timely internal appeal decision);
3. You are or were covered under the plan at the time the service was requested or, in the case of retrospective review, were covered under the plan when the service was provided; and
4. You have provided all of the information and forms necessary to process the external review.

External Review will be conducted by Independent Review Organizations (IRO) accredited by a nationally recognized accrediting organization.You will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review your claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

Medical Mutual is required by law to provide to the independent review organization conducting the review, a copy of the records that are relevant to your medical Condition and the external review. The IRO will review the claim without being bound by any decisions or conclusions reached during the internal claim and appeal process.

External Review for Non-Urgent Care Claim Appeals

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to Medical Mutual's Member Appeals Unit at the address listed above.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will notify you and give you ten business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. This written decision will include the main reasons for the decision, including the rationale for the decision.The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either Medical Mutual or you. If the IRO reverses the adverse benefit determination, Medical Mutual will provide coverage or payment for the claim.

Expedited External Review for Urgent Care Claim Appeals

A request for an external review for Urgent or Expedited claims may be requested orally or electronically or in writing and should be addressed to Medical Mutual's Member Appeals Unit. You may request an external review for Urgent or Expedited claims at the same time you request an expedited internal appeal of your claim.

An expedited review may be requested if your Condition, without immediate medical attention, could result in serious jeopardy to your life or health or your ability to regain maximum function; or you have received a final internal appeal denial concerning an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation.This decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either Medical Mutual or you. If the IRO reverses the adverse benefit determination, Medical Mutual will provide coverage or payment for the claim.

Voluntary Internal Review Process

Unless your Group requires you to use an alternative dispute resolution procedure, if your internal mandatory appeal is denied, and your claim does not qualify for an external review, you have the option of a voluntary internal review by Medical Mutual. All requests for appeal may be made by calling Customer Service or writing to the Member Appeals Department.You should submit additional written comments, documents, records, dental X-rays, photographs and other information that were not submitted for the internal mandatory appeal.

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

The voluntary internal review provides a full and fair review of the claim. The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the internal mandatory appeal.

Claim Review

Consent to Release Medical Information - Denial of Coverage

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

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

Right to Review Claims

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

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

Legal Actions

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

Coordination of Benefits

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 attempt to resolve the problem by contacting Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card.

Right of Subrogation and Reimbursement

Subrogation

The Plan reserves the right of subrogation. This means that, to the extent the Plan provides or pays benefits or expenses for Covered Services, the Plan assumes your legal rights to recover the value of those benefits or expenses from any person, entity, organization or insurer, including your own insurer and any under insured or uninsured coverage, that may be legally obligated to pay you for the value of those benefits or expenses. The amount of the Plan's subrogation rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of subrogation shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of subrogation for the total amount the Plan paid for Covered Services is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. This provision is intended to and does reject and supersede the "make-whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of subrogation.

Reimbursement

The Plan also reserves the right of reimbursement. This means that, to the extent the Plan provides or pays benefits or expenses for Covered Services, you must repay the Plan any amounts recovered by suit, claim, settlement or otherwise, from any third party or his insurer and any under insured or uninsured coverage, as well as from any other person, entity, organization or insurer, including your own insurer, from which you receive payments (even if such payments are not designated as payments of medical expenses). The amount of the Plan's reimbursement rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of reimbursement shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of reimbursement for the total amount the Plan paid for Covered Services is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. This provision is intended to and does reject and supersede the "make whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of reimbursement.

Your Duties

- You must provide the Plan or its designee any information requested by the Plan or its designee within five (5) days of the request.
- You must notify the Plan or its designee promptly of how, when and where an accident or incident resulting in personal injury to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan or its designee in the investigation, settlement and protection of the Plan's rights.
- You must send the Plan or its designee copies of any police report, notices or other papers received in connection with the accident or incident resulting in personal injury to you.
- You must not settle or compromise any claims unless the Plan or its designee is notified in writing at least thirty (30) days before such settlement or compromise and the Plan or its designee agrees to it in writing.

Discretionary Authority

Medical Mutual shall have discretionary authority to interpret and construct the terms and conditions of the Subrogation and Reimbursement provisions and make determination or construction which is not arbitrary and capricious. Medical Mutual's determination will be final and conclusive.

Changes In Benefits or Provisions

The benefits provided by this coverage may be changed at any time. It is your Group's responsibility to notify you when these changes go into effect. If you are receiving Covered Services under this Benefit Book at the time your revised benefits become effective, the Plan will continue to provide benefits for these services only if they continue to be Covered Services under the revised benefits.

Termination of Coverage

How and When Your Coverage Stops

Your coverage as described in this Benefit Book, stops:

- When the Card Holder fails to make the required contributions.
- On the date that a Covered Person stops being an Eligibile Dependent.
- On the date that a Card Holder becomes ineligible.
- On the day a final decree of legal separation, divorce, annulment or dissolution of the marriage is filed, a Card Holder's spouse will no longer be eligible for coverage under the Plan.
- Immediately upon notice if:
  - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
  - a Covered Person intentionally misrepresents a material fact provided to the Group or Medical Mutual or commits fraud or forgery. If your coverage is rescinded, you will be given 30 days' advance written notice, during which time you may request a review of the decision.

Federal Continuation Provisions - COBRA

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

When You Are Eligible for COBRA

If you are a Card Holder and active employee covered under your employer's group health plan, you have the right to choose this continuation coverage if you lose your group health coverage because of reduction in your hours of employment or termination of employment (for reasons other than gross misconduct on your part) or at the end of a leave under the Family and Medical Leave Act. If you are 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 Card Holder (active employee or retiree for number 5 below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the employer's plan for any of the following reasons:

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

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

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

Notice Requirements

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

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

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

How Long COBRA Coverage Will Continue

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

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

If you are a former employee and you have a newborn or adopted child while you are on COBRA continuation and you enroll the new child for coverage, the new child will be considered a "qualified beneficiary." This gives the child additional rights such as the right to continue COBRA benefits even if you die during the COBRA period. Also, this gives the right to an additional 18-month coverage if a second qualifying event occurs during the initial 18-month COBRA period following your termination or retirement. If you are entitled to 18 months of continuation coverage and if the Social Security Administration determines that you were disabled within 60 days of the qualifying event, you are eligible for an additional 11 months of continuation coverage after the expiration of the 18-month period. To qualify for this additional period of coverage, you must notify the Group within 60 days after becoming eligible for COBRA or receiving a disability determination from the Social Security Administration, whichever is later. Such notice must be given before the end of the initial 18 months of continuation coverage. If the individual entitled to the disability extension has non-disabled family members who are qualified beneficiaries and have COBRA coverage, those non-disabled beneficiaries will also be entitled to this 11-month disability extension. During the additional 11 months of continuation coverage, the premium for that coverage may be no more than 150% of the coverage cost during the preceding 18 months.

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

1. your Group no longer provides group health coverage to any of its employees;
2. the premium for your continuation coverage is not paid in a timely fashion;

3. you first become, after the date of election, covered under another group health plan (unless that other Plan contains an exclusion or limitation with respect to any preexisting Condition affecting you or a covered dependent); or
4. you first become, after the date of election, entitled (that is covered) under Medicare.

Additional Information

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

You do not have to provide proof of insurability to obtain continuation coverage. However, under COBRA, you will have to pay all of the premium (both employer and employee portion) for your continuation coverage, plus a 2% administrative fee. You will have an initial grace period of 45 days (starting with the date you choose continuation coverage) to pay any premiums then due; after that initial 45-day grace period, you will have a grace period of 30 days to pay any subsequent premiums.

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

Continuation of Coverage During Military Service

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

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

Benefits After Termination of Coverage

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

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

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

Rescission of Coverage

A rescission of coverage means that your coverage is retroactively terminated to a particular date, as if you never had coverage under the Plan after the date of termination. 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 may also be rescinded for any period of time for which you did not pay the required contribution to coverage, including COBRA premiums.

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.

Multi-Language Interpreter Services & Nondiscrimination Notice

MEDICAL MUTUAL®

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

Spanish

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

Chinese

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

German

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

Arabic

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

Pennsylvania Dutch

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

Russian

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

French

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

Vietnamese

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

Navajo

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

Oromo

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

Korean

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

Italian

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

Japanese

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

Dutch

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

Ukrainian

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

Romanian

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

Tagalog

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

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

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

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

Nondiscrimination Notice

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

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

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

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

Email: CivilRightsCoordinator@MedMutual.com

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

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

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