

# **JOHN CARROLL UNIVERSITY**

**Group Number  
226685-208**



# **Medifil Benefit Book**

## **Supplemental Major Medical Rider**

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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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NSTM-ASO2421  
STSM-ASO2472RS  
NSTSM-ASO2452R  
AMENDMENT LGNO DRUG  
X9688 2/16 (AMENDMENT TELEHEALTH)





## AMENDMENT

This Amendment modifies the coverage described in your Certificate/Benefit Book and is effective at the time of your plan's next renewal occurring on or after May 1, 2016. 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 Certificate/Benefit Book for future reference.

1. The following definition is added:

**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.

2. The following is added to the Drugs and Biologicals Health Care Benefit:

- 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 and/or age limits for specific Prescription Drugs. Covered Services will be limited based upon Medical Necessity, quantity and/or age limits established by Medical Mutual or utilization guidelines. Medical Mutual may require utilization programs, such as Step Therapy, Prior Authorization, or Quantity Limits 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. The 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.

IN WITNESS  
WHEREOF:

Medical Mutual

Steven C. Glass  
President & CEO







## CERTIFICATE/BENEFIT BOOK AMENDMENT (Telehealth)

**This Amendment modifies the coverage described in your Certificate Book/Policy and is effective on May 1, 2016. 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 Certificate Book/Policy for future reference.**

1. The following exclusion is added and replaces any existing exclusion for telephone or online consultations:

For telephone consultations or consultations via electronic mail, facsimile or internet/web site, except as required by law, authorized by Us, or as otherwise described in this Certificate Book/Policy.

2. The following is added to the office visit section of the Health Care Benefit entitled, "Medical Care:"

**Services not performed in-person.** When performed by a Provider with whom Medical Mutual has an agreement to perform these services, your coverage will include Providers' charges for consulting with Covered Persons by telephone, facsimile machine, electronic mail systems or online visit services. Online Covered Services include a medical consultation using the internet via a webcam, chat or voice. Non Covered Services include, but are not limited to, communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Requests for referrals to doctors outside the online care panel
- Benefit precertification
- Physician-to-Physician consultation

IN WITNESS  
WHEREOF:

Medical Mutual

Steven C. Glass  
President & CEO

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





## MEDICAL MUTUAL®

For Use With Non-Grandfathered Group PPO, POS and Indemnity Plans

### PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

#### AMENDMENT

**This Amendment amends your health benefit Plan (Plan), and becomes a part of your Plan as of the first day of the Plan's first Plan year on or after September 23, 2010, the Effective Date. Please place this Amendment with your certificate for future reference.**

On the Effective Date of this Amendment, certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010 (PPACA).

Regardless of the terms and conditions of any other provisions of your Plan, this Amendment will control.

**The following Definition is added to your Plan:**

**"Essential Health Benefits"** is 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. Your Plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your Plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this Amendment.

#### **Emergency Services**

**"Stabilize"** means, to provide such medical treatment of an Emergency Medical 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.

Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department.

For PPO and POS Plans only: Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from an out of network provider. However, an out of network provider of Emergency Services that does not have a contract with Medical Mutual may send you a bill for any charges remaining after your Plan has paid (this is called "balance billing").

Except where your Plan provides a better benefit, your Plan will apply the same copayments and coinsurance for out of network Emergency Services as it generally requires for in network Emergency Services. A deductible may be imposed for out of network Emergency Services, only as part of the deductible that generally applies to out of network benefits. Similarly, any out-of-pocket maximum that generally applies to out of network benefits will apply to out of network Emergency Services.

Your Plan will calculate the amount to be paid for out of network Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount your Plan pays to in network providers for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with in-network providers for the services furnished); 2) the amount that would be paid using the same method your Plan generally uses to determine payment for out of network services (the Non-Contracting Amount) but substituting in network copayments and coinsurance amounts; and (3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any in network copayments or coinsurance.

### **Lifetime Dollar Limits**

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan's terms, and that Plan is still in effect, you should have received a notice that the lifetime dollar limit no longer applies and an opportunity to enroll or be reinstated under your Plan. Covered Persons who are eligible for this enrollment opportunity are treated as special enrollees.

### **Annual Dollar Limits**

Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. Your Plan may include other benefits not defined as Essential Health Benefits, and those other benefits may have annual dollar limits.

The dollar amount of any lifetime limit that was in effect as of March 23, 2010, is your Plan's benefit period maximum for Essential Health Benefits, provided it is no less than \$750,000.

If your Plan has annual dollar limits on Essential Health Benefits they are subject to the following:

For a Plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit can be no less than \$750,000.

For a Plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit can be no less than \$1.25 million.

For a Plan year beginning on or after September 23, 2012, but before January 1, 2014, the limit can be no less than \$2 million.

For a Plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan.

Any other annual dollar limits on Essential Health Benefits that may have existed are deleted.

### **Rescission of Coverage**

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

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

### **Preventive Health Benefits**

Under Ohio law, the following preventive health benefits are required to be provided in your Plan:

- Initial Mammography starting at age 35
- Annual screening for cervical cancer
- Child Health Supervision

Your Plan provides additional coverage for selected preventive services, as shown below. These preventive services will be covered without a copayment, coinsurance or deductible. However, for PPO and POS Plans, no copayment, coinsurance or deductible will apply when these services are delivered by a network provider. Depending upon your age, services may include:

- Screenings and tests for diseases
- Mental Health screenings, including substance abuse
- Healthy lifestyle counseling
- Vaccines and immunizations
- Pregnancy counseling and screenings
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Please contact us at MedMutual.com or at the phone number shown on your ID 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/prevention/index.html](http://www.healthcare.gov/prevention/index.html).

### **Dependent Coverage** (for Plans that make dependent coverage available)

#### **Federal law**

This Plan will cover your married or unmarried child as defined in the Eligibility section of this Plan until your child reaches age 26.

### **Internal Claims and Appeals and External Review Process:**

1. The following is added to the list of information included in all notices of a denial of a benefit determination:
  - a. Sufficient information to identify the claim, including the date of services, the health care provider, and the claim amount, if applicable.
  - b. In the case of a final internal benefit determination, a discussion as to how the decision was made.
2. The provision for Filing an Appeal is amended as follows:
  - a. Under the Expedited Review Process:

1. Expedited reviews will be resolved within 72 hours after you have submitted the request.
  2. When you request an internal appeal for an urgent care claim or for a concurrent care claim that is urgent, you may also file a request at the same time for an external appeal.
- b. You may also file an appeal for the following:
1. A determination of your eligibility to participate in the plan or health insurance coverage.
  2. A decision to rescind your coverage. (A rescission does not include a retroactive cancellation for failure to timely pay required premiums.)
- c. You will receive continued coverage pending the outcome of the appeals process. This means that Medical Mutual may not reduce or eliminate coverage of ongoing treatment until your appeal is exhausted.
3. The provision for First Level Mandatory Appeal for Medical Necessity Denial is amended as follows:
- a. Health care professionals who review the appeal 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.
  - b. You may submit written comments, documents, records, as well as testimony and other information relating to the claim being appealed.
  - c. If, during the appeal, Medical Mutual considers, relies upon or generates any additional evidence, you will be provided free of charge with copies of that evidence. You will have an opportunity to respond before our time frame for making a decision has expired.
  - d. All notices of a denial of benefits will include sufficient information to identify the claim, including the date of services, the health care provider and the claim amount, if applicable.
  - e. If Medical Mutual has not substantially complied with the internal claims appeals process, you may choose to initiate the external appeal process.
4. The provision for External Review for Urgent Care Claim Appeals is amended as follows:
- a. You may also request an external review for Urgent or Expedited claims at the same time you request an internal review of your claims.
  - b. The review panel will issue a written decision within seventy-two hours after you have submitted the request.

### **No Preexisting Condition Limitations for Covered Persons under age 19**

Any Preexisting Condition Limitations described in the Schedule of Benefits of your Plan do not apply to Covered Persons who are under 19 years of age. With respect to Covered Persons who are under 19 years of age, your Plan covers any condition that may have been previously excluded by name or specific description as a pre-existing condition. This also means a Covered Person under the age of 19 cannot be excluded from the Plan if the exclusion is based on a preexisting condition.

### **For Point-of-service Plans:**

#### **Direct Access to Obstetricians and Gynecologists: For Point-of-service Plans**

You do not need prior authorization from us or any other person (including a primary care provider) 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 Provider

We generally require the designation of a primary care provider. You have the right to designate any primary care provider 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 provider.

Until you make this designation, Medical Mutual designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Medical Mutual at the phone number shown on your ID card or at MedMutual.com.

This Amendment takes effect on the first day of the Plan's first Plan year on or after September 23, 2010. This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

IN WITNESS WHEREOF:

Medical Mutual of Ohio

A handwritten signature in black ink, appearing to read "S. C. Glass", with a stylized flourish at the end.

Steven C. Glass  
President and CEO





# MEDIFIL 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. 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 of Ohio, 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 Plan and are referred to as **Covered Persons, you or your**. They must:

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

The Group and Medical Mutual shall 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.

**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.

This Benefit Book should be read and re-read in its entirety. Many of the provisions of this Benefit Book are interrelated; therefore, reading just one or two provisions may not give you an accurate impression of your coverage.

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.

Many words used in this Benefit Book have special meanings. These words will appear capitalized and are defined for you in the Definitions section. By reviewing these definitions, you will have a clearer understanding of your Benefit Book.

## HOW TO USE YOUR BENEFIT BOOK

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

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.

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

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

## DEFINITIONS

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

**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.

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

**Benefit Book** - this document.

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

**Billed Charges** - Charges for all services and supplies that the Covered Person has received from the Provider, whether they are a Covered Service or not.

**Birth Year** - a 12 month rolling year beginning on the individual's birth date.

**Card Holder** - an Eligible Employee or member of the Group who has enrolled for coverage under the terms and conditions of the Plan and persons continuing coverage pursuant to COBRA or any other legally mandated continuation of coverage.

**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.

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

**Contracting** - the status of a Hospital or Other Facility Provider:

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

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

**Covered Person** - the 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.

**Creditable Coverage** - coverage of an individual under any of the following:

- a group health plan, including church and governmental plans;
- health insurance coverage;
- Part A or Part B of Title XVIII of the Social Security Act (Medicare);
- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 (Medicaid);
- the health plan for active military personnel, including TRICARE;
- the Indian Health Service or other tribal organization program;
- a state health benefits risk pool;
- the Federal Employees Health Benefits Program;
- a public health plan as defined in federal regulations;
- a health benefit plan under section 5 (c) of the Peace Corps Act; or
- any other plan which provides comprehensive hospital, medical and surgical services.

**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 custody of a child.

**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.

**Effective Date** - 12:01 a.m. on the date when your coverage under the Plan begins, as determined by your Group.

**Emergency** - an accidental traumatic bodily injury or other medical Condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- place 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 Admission** - an Inpatient admission to a Hospital directly from a Hospital emergency room.

**Emergency Care** - Covered Services that are furnished by a Provider within the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

**Emergency Services** - a medical screening examination as required by Federal Law that is within the capability of the Emergency Department of the Hospital, including ancillary services routinely available to the Emergency Department to evaluate an Emergency medical Condition; and further medical examination and treatment that are required to Stabilize an Emergency medical Condition and within the capabilities of the staff and facilities available at the Hospital, including any trauma or burn center at the Hospital.

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

**Excess Charges** - the amount of Billed Charges in excess of the covered Traditional Amount or Non-Contracting Amount determined payable by Medical Mutual for a Non-Contracting Institutional Provider, a Non-Participating Physician or Other Professional Provider.

**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 furnished;
- if reliable evidence shows that the drug, device, medical treatment or procedure 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 regarding the drug, device, medical treatment or procedure is 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 means only published reports and articles in the authoritative medical and scientific literature; 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; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure. Determination will be made by Medical Mutual at its sole discretion and will be final and conclusive, subject to any available appeal process.

**Federally Eligible Individual** -

- an individual who has had an 18-month period of Creditable Coverage with final coverage through an employer group plan, governmental plan or church plan. Coverage, after which there was a break of more than 63 days does

not count in the period of Creditable Coverage. Creditable Coverage will be counted based on the standard method without regard to specific benefits;

- an individual who must apply within 63 days of the end of the termination date of his or her coverage under the group policy;
- an individual must not be eligible for coverage under a group health plan, Medicare or Medicaid;
- an individual must not have other health insurance coverage;
- an individual whose most recent prior coverage has not been terminated for nonpayment of premium or fraud; and
- if the individual elected COBRA coverage or state continuation coverage, the individual must exhaust all such continuation coverage to become a Federally Eligible Individual. Termination for non-payment of premium does not constitute exhausting such coverage.

**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.

**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.

**Inhospital Benefit Period** - a Period of time beginning when you enter a Hospital or Skilled Nursing Facility and ending when you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

**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.

**Lesser Amount** - for Contracting and Participating Providers, the Lesser Amount means the Lesser of the Negotiated Amount or the Covered Charges. For Non-Participating Physicians and Other Professional Providers, the Lesser Amount means the lesser of the Billed Charges or Traditional Amount. For Non-Contracting Institutional Providers, the Lesser Amount means the Non-Contracting Amount.

**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.

**Medicare Assignment** - an agreement between Medicare and a Provider. The Provider agrees to accept the Medicare Reasonable Charge as payment in full for services rendered to you.

**Medicare Eligible Expenses** - health care expenses approved for payment under Medicare recognized as a Medicare Reasonable Charge. Payment of benefits by Medical Mutual for Medicare Eligible Expenses is conditioned upon a determination of Medical Necessity.

**Medicare Reasonable Charge** - the maximum amount approved by Medicare for payment of a Covered Service or supply.

**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.

The Negotiated Amount for Institutional Providers does not include adjustments and/or settlement due to prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim.

The Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings, volume based credits or refunds or discount guarantees.

The Negotiated Amount for Contracting Institutional Providers may exceed the Covered Charges.

The Negotiated Amount for Participating Physicians and Other Professional Providers does not include any performance withhold adjustments.

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.

**Non-Contracting** - the status of a Hospital or Other Facility Provider that does not meet the definition of a Contracting Institutional Provider.

**Non-Contracting Amount** - the maximum amount determined as payable and allowed by Medical Mutual for a Covered Service provided by a Non-Contracting Institutional Provider.

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

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

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

- **Alcoholism Treatment Facility** - a facility which 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 which 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 which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- **Drug Abuse Treatment Facility** - a facility which mainly provides detoxification and/or rehabilitation treatment for Drug Abuse.
- **Home Health Care Agency** - An Other Facility Provider which provides Home Health Care services and is recognized by Medicare.
- **Hospice Facility** - a facility which provides supportive care for terminally ill patients as specified in the Hospice Services section of this Benefit Book.

- **Psychiatric Facility** - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.
- **Psychiatric Hospital** - a facility which 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 which is recognized by Medicare and 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;
- 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 vocational nurse (L.V.N.);
- mechanotherapist (licensed or certified prior to November 3, 1975);
- nurse-midwife;
- occupational therapist;
- physician assistant;
- podiatrist;
- Psychologist;
- registered nurse (R.N.);
- registered nurse anesthetist; and
- Urgent Care Provider.

**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.

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

**Part A Coinsurance** - the amounts you are required by Medicare to pay for expenses Incurred during an Inpatient stay at a Hospital or Skilled Nursing Facility.

**Part A Deductible** - the specified dollar amount you are required by Medicare to pay for Part A services per Medicare Benefit Period for an Inpatient Hospital admission.

**Part B Coinsurance** - The amounts you are required by Medicare to pay for Part B services after the Part B Deductible has been met.

**Part B Deductible** - the specified dollar amount you are required by Medicare to pay for Part B services per Calendar Year.

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

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

**Prescription Order** - the request for medication by a Physician appropriately licensed to make such a request in the ordinary course of professional practice.

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

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

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

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

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

**Rider** - a document that amends or supplements your coverage.

**Routine Services** - Services not considered Medically Necessary.

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

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

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

**Stabilize** - the provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your Condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

**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.

**Traditional Amount** - the maximum amount determined and allowed by Medical Mutual for a Covered Service provided by a Physician or Other Professional Provider based on factors, including the following:

- the actual amount billed by a Provider for a given service
- Center for Medicare and Medicaid Services (CMS)'s Resource Based Relative Value Scale (RBRVS)
- other fee schedules
- input from Participating Physicians and wholesale prices (where applicable)
- geographic considerations; and
- other economic and statistical indicators and applicable conversion factors.

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

- 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 Provider** - an Other Professional Provider that performs services for health problems that require immediate medical attention that are not Emergencies.

# ELIGIBILITY

## Enrolling for Coverage

In order to qualify as a Card Holder, you must be enrolled in both Part A and Part B of Medicare.

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.

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.

## Eligible Employee

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.

## Eligible Dependents

Dependent coverage is not available under this plan, unless the dependent spouse or child is enrolled in both Part A and Part B of Medicare and meets one of the criteria below for an Eligible Dependent. Any other Eligible Dependent of the Card Holder will be issued coverage under a separate Benefit Book.

An Eligible Dependent is the Card Holder's:

- Spouse; or
- Natural child, stepchild, legally adopted child or child placed for adoption, legal guardian or custodian, any of whom is under age 26.

An Eligible Dependent also includes any child who, by court order, must be provided health care coverage by the Card Holder or the Card Holder's spouse.

Eligibility will continue beyond age 26 for Eligible Dependents who are unmarried and primarily dependent upon the Card Holder for support due to a physical handicap or mental retardation which renders them unable to work. 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.

## Child Support Order

In general, a medical child support order is a court order that requires an Eligible Employee to provide medical coverage for his or her children in situations involving divorce, legal separation or paternity dispute. A medical child support order 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 a medical child support order that is entered by a court of competent jurisdiction or by a local child support enforcement agency. The Group will promptly notify affected Card Holders if a medical child support order is received. The Group will notify these individuals of its procedures for determining whether medical child support orders meet the requirements of the Plan; within a reasonable time after receipt of such order, the Group will determine whether the order is acceptable and notify each affected Card Holder and of its determination. Once the dependent child is enrolled under a medical child support order, the child's appointed guardian will receive a copy of all pertinent information provided to the Eligible Employee. In addition, should the Eligible Employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

## Effective Date

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

## **Benefit Period**

You have a calendar year Benefit Period.

## **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 benefits administrator who must then notify Medical Mutual of the change.

Coverage for a spouse and other 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 the 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**

If you were eligible to enroll under the Plan and declined coverage because of other coverage, and you or your dependent lose the other coverage, you and your Eligible Dependent(s) will be permitted to enroll during a special enrollment period if loss of the other coverage was due to:

- termination of employment;
- a reduction in hours of employment;
- termination of the other coverage;
- termination of employer contributions toward coverage;
- the exhaustion of COBRA continuation coverage;
- the exhaustion of applicable lifetime benefits under the coverage;
- an individual ceases to be a dependent under the plan;
- the plan terminates a benefit package option;
- if your coverage is provided through a Health Maintenance Organization (HMO) or other arrangement, and you no longer live or work in the HMO's or other arrangement's service area (and there is no other coverage available under the plan);
- the plan no longer offers coverage to a class of similarly situated individuals that includes you (e.g., the plan terminates coverage for all part-time employees);
- layoff; or
- the death of or divorce from your spouse.

Enrollment must be supported by written documentation of the termination of the other coverage (including the effective date of the termination). Notice of intent to enroll must be provided to Medical Mutual within 31 days of the event with coverage to be effective on the date the other coverage terminated.

In addition, 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 31 days after the marriage, birth, adoption or placement for adoption.

## **Your Identification Card**

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

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

# HEALTH CARE BENEFITS

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

Part A of Medicare pays part of your Inpatient care in a Hospital or Skilled Nursing Facility, home health care services and hospice care services. Part B of Medicare pays toward certain professional charges, Outpatient Hospital services, and a number of other medical services and supplies not covered by Part A of Medicare. Medicare does not pay the full cost of this care. You are responsible for certain Deductibles and Coinsurance when you receive Medicare Covered Services. For more information on what Medicare covers, read **Medicare & You**. You can get a copy from any Social Security office.

This Benefit Book supplements your Medicare benefits. It provides you with the coverage for the Deductibles and Coinsurance which Medicare does not pay.

This benefit section has been divided into Parts A and B as Medicare has done; please read each section carefully.

## Part A Benefits - Inpatient Benefits

In the United States, the Plan will provide benefits for Covered Services received only in Hospitals and Skilled Nursing Facilities approved by Medicare. When you are outside of the United States, the Plan will provide benefits for Covered Services received in Hospitals if such services would have been covered by Medicare and this Benefit Book if you had received them within the United States.

If, after your Effective Date, you are admitted to a Hospital as an Inpatient, the Plan will provide coverage for the following benefits not covered by Medicare:

1. The Part A Deductible for the first 60 days of Hospital care per Medicare Benefit Period.
2. The Part A Coinsurance for the 61st through the 90th day of Hospital care per Medicare Benefit Period.
3. The Part A Coinsurance for lifetime reserve days.
4. The first three pints of blood that you receive each calendar year.
5. After you have used all of the Hospital days provided to you by Medicare, Medical Mutual will provide benefits for 365 additional days of Hospital care per Inhospital Benefit Period. The Plan will provide 100% of the Lesser Amount to a Contracting Institutional Provider. You are responsible for 30% of the Covered Charges to a Non-Contracting Institutional Provider.

Note: Non-Contracting Providers will pay the same as Contracting Providers but may be subject to balance billing and/or Excess charges. Payments to Contracting Providers are based on the Lesser Amount. Payments to Non-Contracting Providers are based on Covered Charges.

If, after your Effective Date, you are admitted to a Skilled Nursing Facility and the admission is eligible for Medicare payments, Medical Mutual will provide benefits for the Part A Coinsurance for the 21st through the 100th day of care in a Skilled Nursing Facility. (Medicare provides benefits, in full, for the first 20 days.)

## Part A Benefits - Outpatient Benefits

Medical Mutual will provide benefits for the Part A Coinsurance for hospice care services and home health care services.

## Part B Benefits

For Part B Medicare Eligible Expenses:

- the Plan will provide benefits for the Part B Deductible which Medicare does not cover;
- the Plan will provide benefits for the Part B blood deductible for the first three pints of blood each calendar year;

- the Plan will provide benefits for the Part B Coinsurance for Medicare Eligible Expenses; and
- when your Provider does not accept the Medicare Assignment, the Plan will provide benefits for the Part B Coinsurance. If the Traditional Amount is higher than the Medicare Reasonable Charge, the Plan will provide benefits for the difference; subject to balance billing limits established by the state or federal laws or regulations.

For health care services and supplies received while traveling outside the United States, the Plan will provide benefits for the Traditional Amount if services or supplies are Part B Medicare Eligible Expenses when received within the United States.

### **Changes In Medicare Deductibles and Coinsurance**

Medical Mutual will continue to cover the Part A and Part B Deductibles and Coinsurance even if they are changed by Medicare, that is, if Medicare changes Deductible amounts and Coinsurance percentages, the benefits designed to cover these cost sharing amounts will be changed automatically.

## EXCLUSIONS

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

1. For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits.
2. For any expense Incurred within the United States which is not a Medicare Eligible Expense.
3. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
4. Not performed within the scope of the Provider's license.
5. Received from other than a Provider.
6. For Experimental or Investigational equipment, drugs, devices, services, supplies, tests, medical treatments or procedures.
7. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
8. For a Condition that occurs as a result of any act of war, declared or undeclared.
9. For which you have no legal obligation to pay in the absence of this or like coverage.
10. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
11. Received from a member of your Immediate Family.
12. Incurred after you stop being a Covered Person except as specified in the Benefits After Termination of Coverage section.
13. For the following:
  - physical examinations or services required by an insurance company to obtain insurance;
  - physical examinations or services required by a governmental agency such as the FAA and DOT;
  - physical examinations or services required by an employer in order to begin or to continue working;
  - premarital examinations;
  - screening examinations, except as covered by Medicare;
  - X-ray examinations made without film; or
  - routine or annual physical examinations, except as covered by Medicare.
14. For a Condition occurring in the course of employment or for occupational injuries sustained by sole proprietors, if whole or partial benefits or compensation could be available under the laws of any governmental unit. This applies whether or not you claim such compensation or recover losses from a third party.
15. Received in a military facility for a military service related Condition.
16. For Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss or weight loss Surgery), except as specified.
17. For Surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment.
18. For the removal of tattoos.
19. For dietary and/or nutritional counseling or training, except as may be specified.
20. For Outpatient educational, vocational or training purposes except as may be specified.
21. For treatment of Conditions related to an autistic disease of childhood, developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.
22. For topical anesthetics.
23. For routine minor non-operative endoscopic procedures, such as colonoscopy.
24. 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.
25. For weight loss drugs.

26. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
27. For weight loss Surgery, including complications resulting from weight loss surgery except as covered by Medicare.
28. For water aerobics.
29. For residential care rendered by a Residential Treatment Facility.
30. For marital counseling.
31. For the medical treatment of sexual problems not caused by a biological Condition.
32. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
33. For Contraceptives.
34. For contraceptive devices which include, but are not limited to, IUD's, diaphragms and cervical caps.
35. For elective sterilization.
36. For reverse sterilization.
37. For artificial insemination or in vitro fertilization.
38. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.
39. For oral implants considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic except when due to trauma, accident or as deemed Medically Necessary by Medical Mutual.
40. For treatment associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
41. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
42. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.
43. For personal hygiene and convenience items.
44. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except those for aphakic patients, keratoconus and soft lenses or sclera shells for use as corneal bandages when needed as a result of Surgery.
45. 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).
46. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them, except as specified.
47. For immunizations, except as covered by Medicare.
48. For massotherapy or massage therapy.
49. For hypnosis and acupuncture.
50. For After Hours Care.
51. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
52. For fraudulent or misrepresented claims.
53. For blood which is available without charge. For Outpatient blood storage services except for the Medicare blood deductibles.
54. For organ transplants other than those covered by Medicare.
55. For Prescription Drugs, except as covered under Part A or Part B of Medicare.
56. For over the counter drugs, vitamins or herbal remedies.
57. For therapeutic and elective abortions.
58. For Inpatient admissions of which the primary purpose would be:
  - diagnostic services;
  - Custodial Care;
  - rest care;
  - environmental change; or
  - treatment by physical meanswhen these services could have been performed on an Outpatient basis, and it was not Medically Necessary that you be an Inpatient to receive them.

- 59. For specialized camps.
- 60. For routine and wellness services, except as covered under Part A or Part B of Medicare.
- 61. For a particular health service in the event that a Non-Contracting Provider waived Copayments, Coinsurance (and/or the Deductible per Benefit Period) no benefits are provided for the health service for which the Copayments, Coinsurance (and/or the Deductible per Benefit Period) are waived.
- 62. For non-Covered Services or services specifically excluded in the text of this Benefit Book.



## GENERAL PROVISIONS

### How to Apply for Benefits

#### Notice of Claim; Claim Forms

All bills must be processed by Medicare before the Plan can provide benefits for Covered Services. A claim must be filed for you to receive benefits.

#### Part A Claims

Many Hospitals or Skilled Nursing Facilities will submit your claim for you. If not, you must send an itemized copy of the bill with a diagnosis and your Explanation of Medicare Benefits (EOMB) form.

#### Part B Claims

A claim will usually be submitted for you by the organization responsible for processing your Medicare Part B claim. Medical Mutual has the right to accept this information in any form, including any automated method.

If the Medicare Part B claim is not submitted by the organization responsible for processing your Medicare Part B claim, you must send Medical Mutual a copy of your EOMB and a completed Medical Mutual claim form. In many cases you can obtain a claim form from your Provider. If your Provider does not have a claim form, Medical Mutual will send you one. Call or write to Medical Mutual and Medical Mutual will send you a form, or you may print a claim form from Medical Mutual's Web site [www.MedMutual.com](http://www.MedMutual.com), under the Members' section.

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.

#### Part A and Part B Claims for Emergency Care in a Foreign Country

For services received outside the United States, you must send Medical Mutual an itemized bill with a diagnosis for Part A and Part B claims and a claim form for Part B claims. Itemized bills should be translated into English whenever possible. If a translation is not available, include a letter describing the services you received. Generally, Medicare does not cover services received in a foreign country so an EOMB will not be available. However, if you receive an EOMB from Medicare for services received in Canada or Mexico, include a copy of your EOMB when filing a claim to Medical Mutual.

#### 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 the correct information on a completed claim or by established automated methods. Medical Mutual may require Provider's notes or other medical records before proof of loss is considered sufficient to determine benefit coverage.

Medical Mutual is not legally obligated to reimburse on behalf of the Plan for Covered Services unless written or electronically submitted proof that Covered Services have been given to you is received. Medical Mutual must receive the claim form and a copy of the EOMB within the same time limits set for submitting your Part A and Part B claims to Medicare.

### How Claims are Paid

Medical Mutual, as the claims administrator pays for benefits on behalf of the Plan for Covered Services through agreements with Contracting Institutional Providers and Participating Physicians and Other Professional Providers based on Negotiated Amounts. For Non-Contracting Institutional Providers, Medical Mutual pays for benefits based on the Non-Contracting Amount that is determined payable by Medical Mutual. For Non-Participating Physicians and Other Professional Providers, Medical Mutual pays for benefits based on Traditional Amounts.

## **Your Financial Responsibilities**

**You are responsible for paying Non-Covered Charges, Billed Charges for all services and supplies after benefit maximums have been reached and Excess Charges for services and supplies rendered by Non-Contracting and Non-Participating Providers.** You are responsible for payment for services that are not Medically Necessary and for incidental charges.

For Covered Services rendered by Contracting Institutional Providers, Physicians and Other Professional Providers, Medical Mutual will calculate your Coinsurance and benefit maximum accumulations based on the Lesser Amount. Your financial responsibility to the Provider for Covered Services will also be based on the Lesser Amount. For Non-Participating Physicians and Other Professional Providers you may be responsible for Excess Charges.

For Covered Services received from Contracting Institutional Providers and Participating Physicians and Other Professional Providers, the Provider has agreed not to bill for any amount of Covered Charges above the Negotiated Amount, except for services and supplies for which Medical Mutual has no financial responsibility due to a benefit maximum.

For Covered Services rendered by Non-Contracting Institutional Providers, Medical Mutual will calculate your Coinsurance and benefit maximum accumulations based on the Non-Contracting Amount as determined by Medical Mutual. You may be responsible for Excess Charges.

Amounts paid by other parties do not accumulate towards benefit maximums.

## **Provider Status and Direction of Payment**

Medical Mutual has agreed to make payment directly to Contracting Institutional Providers and Participating Physicians and Other Professional 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, Coinsurance and benefit maximums, if applicable, will be calculated as described in this Benefit Book.

The choice of a Provider is yours. After a Provider performs a Covered Service, Medical Mutual will not honor your request to withhold claim payment. Medical Mutual and the Group do not furnish Covered Services but only pays for Covered Services you receive from Providers. Neither Medical Mutual nor the Group is liable for any act or omission of any Provider. Neither Medical Mutual nor the Group have any responsibility for a Provider's failure or refusal to give Covered Services to you.

Medical Mutual has 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 Medical Mutual Providers as Contracting.

Medical Mutual is authorized to make payments directly to Providers who have performed Covered Services for you. Medical Mutual also reserves the right to make payment directly to you. When this occurs, you must pay the Provider and neither Medical Mutual nor the Group are legally obligated to pay any additional amounts. You cannot assign your right to receive payment to anyone else nor can you authorize someone else to receive your payments for you, including your Provider.

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

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

## **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 and a copy of the EOMB. 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.

## Compliant and Inquiry Procedure

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

## Filing an Appeal

If you are not satisfied with the benefit determination decision, you may file an appeal. No more than two appeals on one claim will be conducted in accordance with the procedures explained below.

To file an appeal, please call the Customer Service telephone number on your identification card or 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; date of services; the Provider/facility name; and any supporting information or records, X-rays or photographs you would like considered in the appeal. Send or fax the letter to:

Medical Mutual of Ohio, LLC (Medical Mutual)  
Member Appeals Unit  
MZ 01-1B-4809  
P.O. Box 94580  
Cleveland, OH 44101-4580  
Fax (216) 687-7990

To submit an appeal form electronically, go to Medical Mutual's Web site, [www.MedMutual.com](http://www.MedMutual.com), under the Members' section.

### First Level Mandatory Appeal

The Plan offers all Card Holders a first level mandatory appeal. You must complete this first level of appeal before any additional action is taken.

First level mandatory appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of benefits. A request for appeal may be made by calling Customer Service or in writing as described above.

Under the appeal process there will be a full and fair review of the claim. The internal appeal process is a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into account all comments, documents, records and other information submitted by you and your Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations of Medical Necessity that are based, in whole or in part, on a medical judgment are made by 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 decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

You may submit written comments, documents, records and other information relating to the claim being appealed. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that you are appealing.

All notices of a denial will include the following:

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, then that information will be provided free of charge upon written request;
- If the claim was denied based on a Medical Necessity or Experimental treatment or 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 provided free of charge upon request;
- upon specific written request from you, 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.

### **Voluntary Second Level Appeal**

Unless your Group requires you to use an alternative dispute resolution procedure, if your first level mandatory appeal was denied, you have the option of a voluntary second level appeal by Medical Mutual. All requests for appeal may be made by calling or writing to Customer Service. You may submit additional written comments, documents, records, X-rays, photographs and other information relating to the claim being appealed.

The second level is voluntary. Any statute of limitations will be applicable during the period of the voluntary appeal process.

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

The voluntary second level of appeal provides a full and fair review of the claim. There will be a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. 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 first level mandatory appeal. All determinations of Medical Necessity, that are based in whole or in part on medical judgement, are made by 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 decisions about your care and will not be a subordinate of the professional who made the initial determination of your claim.

## **Claim Review**

### **Consent to Release Medical Information - Denial of Coverage**

You consent to the release of medical information to Medical Mutual 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.

### **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, precertification 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 spouse'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 under the terms and conditions, as described in this Book, stops:

- On the date under the terms and conditions of the Plan, as described in this Benefit Book, that a Covered Person stops being an Eligible Dependent or if coverage is extended by your Group for Full-time Student status, on the date the Full-time Student status ends. You are responsible for notifying the Group immediately of any change to the eligibility status of a Full-time Student.
- One the date a Card Holder becomes ineligible.
- On the day a final decree of 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 materially misrepresents a material fact provided to the Group or Medical Mutual or commits fraud or forgery.

### **Certificate of Creditable Coverage**

If any Covered Person's coverage would end and the Agreement is still in effect, you and your covered Eligible Dependents will receive a certificate of Creditable Coverage that shows your period of coverage under the Plan.

### **Federal Continuation Provisions - COBRA**

If any Covered Person's group coverage would otherwise end as described above 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 up to 36 months from the date of entitlement (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. (During the last 180 days of your continuation coverage period, you must be allowed to enroll in an individual conversion health plan if one is provided by the Group. However, conversion coverage is not available if the Agreement terminates or the Group goes out of business. Call the Group during your last 180 days of COBRA for information on conversion).

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

### **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.

### **Federally Eligible Individuals**

In addition, you need to be advised of what qualifies you to meet the requirements of a Federally Eligible Individual. Special non-group plans are available to Federally Eligible Individuals. A Federally Eligible Individual is an individual who meets the following requirements:

- an individual must have an 18 month period of Creditable Coverage, with final coverage through a group health plan, including church and governmental plans; health insurance coverage; Part A or Part B of Title XVIII of the Social Security Act (Medicare); the health plan for active military personnel, including TRICARE; the Indian Health Service or other tribal organization program; a state health benefits risk pool; the Federal Employees Health Benefits Program; a public health plan as defined in federal regulations; a health benefit plan under section 5 (c) of the Peace Corps Act; or any other plan which provides comprehensive hospital, medical and surgical services. Coverage after which there was a break of more than 63 days does not count in the period of Creditable Coverage. Creditable Coverage will be counted based on the standard method, without regard to specific benefits.
- an individual must enroll within 63 days of the termination date of your coverage under the group policy coverage;
- an individual must not be eligible for coverage under a group health plan, Medicare or Medicaid;
- an individual must not have other health insurance coverage;
- an individual whose most recent prior coverage has not been terminated for nonpayment of premium or fraud; and
- if the individual elected COBRA coverage or Ohio extension of coverage, the individual must exhaust all such continuation coverage to become a Federally Eligible Individual. Termination for nonpayment of premium does not constitute exhausting such coverage.

## SUPPLEMENTAL MAJOR MEDICAL SCHEDULE OF BENEFITS

Benefit Period	Calendar year
Benefit Period Deductible	\$100
Coinsurance Limit	\$500
Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	\$600

There is no Coinsurance Limit with respect to Non-Contracting Institutional Providers' claims. Any amount of Coinsurance you pay for Covered Services received from a Non-Contracting Institutional Provider will not accumulate towards the Coinsurance Limits. Any Excess Charges you pay for claims will not accumulate towards the Coinsurance Limit.

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

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

COINSURANCE PAYMENTS	Institutional and Professional Charges	Institutional Charges	Institutional Charges
TYPE OF SERVICE	For Covered Services received from a Contracting Institutional Provider or any Physician or Other Professional Provider, you pay the following	For Covered Services received from a Non-Contracting Hospital Skilled Nursing Facility, Home Health Care Agency or Hospice Facility you pay the following	For Covered Services received from a Non-Contracting Other Facility Provider which is not a Hospital, Skilled Nursing Facility, Home Health Care Agency, or Hospice Facility you pay the following
EMERGENCY SERVICES			
Emergency Services	20% of Lesser Amount	20% of Covered Charges	20% of Covered Charges
INPATIENT SERVICES			
Semi-Private Room and Board	20% of Lesser Amount	44% of Covered Charges	50% of Covered Charges
MENTAL HEALTH CARE, DRUG ABUSE AND ALCOHOLISM SERVICES			
Mental Health Care, Drug Abuse and Alcoholism Services	Any applicable Deductible, Coinsurance 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 Mental Illness will be paid according to the Emergency Services section above).		
ROUTINE, PREVENTIVE AND WELLNESS SERVICES			
Routine Immunizations	20% of Lesser Amount	44% of Covered Charges	50% of Covered Charges
Routine Mammograms	20% of Lesser Amount	44% of Covered Charges	50% of Covered Charges
Routine Pap Tests	20% of Lesser Amount	44% of Covered Charges	50% of Covered Charges
OTHER SERVICES			
All Other Covered Services	20% of Lesser Amount	44% of Covered Charges	50% of Covered Charges

## SUPPLEMENTAL MAJOR MEDICAL RIDER

This Rider supplements and amends your Benefit Book. It provides additional coverage for some of the services listed in your Benefit Book. As the Benefit Period maximums for these services are exhausted, benefits will be covered under this Rider.

The Supplemental Major Medical Coverage Rider also provides coverage for additional benefits not included in your Benefit Book.

Except as amended, your Benefit Book remains unchanged. When coverage under your Benefit Book ends, coverage under this Rider also ends.

## DEFINITIONS

In addition to the definitions listed in your Benefit Book, the following definitions also apply to this coverage:

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

**Contraceptives** - oral, injectable, implantable or transdermal patches for birth control.

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

## HEALTH CARE BENEFITS

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

### Allergy Tests and Treatments

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

### Ambulance Services

Transportation services via ambulance must be certified by your Physician and 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 Medical Emergency 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 will also be covered when provided by a professional ambulance service for other than local ground 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.**

### **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.

### **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 are limited to the following:

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

### **Drug Abuse and Alcoholism Services**

Detoxification and rehabilitation services are provided for the treatment of Drug Abuse or Alcoholism. In addition, the following services are also covered for the treatment of Drug Abuse or Alcoholism:

- 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 Drug Abuse or Alcoholism.

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

## Drugs and Biologicals

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

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

## Emergency Care Services

You are covered for Medically Necessary Emergency Care following an Emergency. Chronic Conditions are not considered to be Emergencies unless an acute, life-threatening attack occurs. Emergency Care is available 24 hours a day, 7 days a week. If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital to obtain Emergency Services. **Care and treatment once you are Stabilized is not Emergency Care.** Continuation of care beyond that needed to evaluate or Stabilize your Condition in an Emergency will be covered according to your Schedule of Benefits. Please refer to your Schedule of Benefits for detailed coverage explanation.

## 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 terminally ill Covered Person. 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.

Benefits for hospice services are available when the prognosis of life expectancy is six months or less.

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

Covered ancillary Hospital services include but are not limited to:

- operating, delivery and treatment rooms and equipment;
- Prescription Drugs;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. We will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded. **Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered;**
- 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 psychiatric care, substance abuse or eating disorders.

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

## Maternity Services

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy, miscarriage 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.

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.

## 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 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 Plan Sponsor 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.

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

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

Staff consultations required by Hospital rules are not covered.

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

**Office Visits** - Office Visits to examine, diagnose and treat a Condition are Covered Services.

## 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:

- needles;
- oxygen;
- surgical dressings and other similar items;
- syringes.

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

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

**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;
- crutches;
- home dialysis equipment;
- hospital beds;
- mastectomy bra;
- respirators;
- wheelchairs.

**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;
- 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;
  - Jobst stockings and other compression devices.

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

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

**Non-covered devices include but are not limited to:**

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

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

**Non-covered 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;
- wigs and hair pieces.

## Mental Health Care Services

The following are Covered Services for the treatment of Mental Illness. These services will also be covered when you have a medical Condition that requires Medically Necessary behavioral health treatment.

- 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, developmental delay 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. Contracting Providers in Ohio will assure this preauthorization is done; and since the Provider is responsible for obtaining the preauthorization, there is no penalty to you if this is not done. For Non-Contracting Providers or Providers outside of Ohio, you are responsible for obtaining preauthorization. If you do not preauthorize these admissions and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges.

## Organ and Tissue Transplant Services

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

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

if such services take place during a transplant benefit period. A transplant benefit period is a period of time which starts five days before the day you receive your first covered transplant and ends 12 months later. A new transplant benefit period starts only if the next covered transplant occurs more than 12 months after the last covered transplant was performed. No transplant waiting periods and/or organ transplant maximums will apply to kidney, pancreas/kidney, bone marrow, tissue or cornea transplants.

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

**Organ/Tissue Transplant Pre-Certification** - In order to receive full benefits for an organ/tissue transplant, the proposed course of treatment must be pre-certified and approved by Medical Mutual. In the event you do not obtain precertification,

and your organ transplant is determined to not be Medically Necessary or is determined to be Experimental/Investigational, you may be responsible for all Billed Charges for that organ transplant.

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

- the proposed course of treatment for the transplant;
- the name and location of the proposed Transplant Center; and
- copies of your medical records, including diagnostic reports for Medical Mutual to determine the suitability and Medical Necessity of the transplant services. This determination will be made in accordance with uniform medical criteria that has been specifically tailored to each organ/tissue. 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 or Donor Tissue** - The following services will be Covered Services when they are necessary in order to acquire a legally obtained human organ/tissue:

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

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

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

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

## Outpatient Institutional Services

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

**Covered Institutional services include, but are not limited to:**

- operating, delivery and treatment rooms and equipment;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. 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. **Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered;**
- 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 Therapy Services

Therapy services are services and supplies used to promote recovery from a 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:

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

**Chiropractic Visits** - The treatment given by a chiropractor to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. 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.**

**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.

**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 an appropriately licensed Provider.

**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.**

**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.

**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.

## 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 or as an Inpatient. 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.

Inpatient 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 non-medical 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.

## Routine and Wellness Services

**Immunizations** - The following immunizations are covered:

- diphtheria toxoid
- diphtheria/tetanus toxoids (DT)
- hepatitis B
- herpes zoster (shingles)
- human papillomavirus vaccine (HPV)
- influenza

- MMR (measles, mumps and rubella)
- meningococcal vaccine
- pneumococcal polysaccharide
- rabies vaccine
- tetanus toxoid
- varicella (VSV)

## Skilled Nursing Facility Services

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

### No benefits are provided:

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

## Surgical Services

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

- removal of bony impacted teeth;
- 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 Traditional Amount for the secondary procedures will be half of the Traditional 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 Traditional Amount will be half of the Traditional Amount for the next two most complex procedures. For all other procedures, the Traditional Amount will be one-fourth of the full Traditional Amount.

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

**Anesthesia** - Your coverage includes the administration of anesthesia, performed in connection with a Covered Service, by a Physician, Other Professional Provider or certified registered nurse anesthetist who is not the surgeon or the assistant



at Surgery or by the surgeon in connection with covered oral surgical procedures. This benefit includes care before and after the administration. The services of a stand-by anesthesiologist are only covered during coronary angioplasty Surgery.

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

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

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

## EXCLUSIONS

In addition to the exclusions and limitations explained in the Benefit Book, coverage is not provided for services and supplies:

1. For any amount payable under your Benefit Book or any other health expense coverage. This includes non-group or group plans, health and welfare plans, automobile or home owner insurance and government programs.
2. For amounts you must pay under any Benefit Books or Riders.
3. For amounts you must pay to a Non-Contracting Hospital under your Base coverage.
4. For immunizations, other than those specified as covered in the Routine and Wellness Services section of this Rider.
5. For blood which is available without charge. For Outpatient blood storage services.
6. For Prescription Drugs, except as specified.
7. For Contraceptives, except as specified.
8. For contraceptive devices which include, but are not limited to, IUD's, diaphragms and cervical caps.
9. For weight loss drugs.
10. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
11. For weight loss Surgery and any repairs, revisions or modifications of such Surgery, including weight loss device removal.
12. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except those for aphakic patients, keratoconus, and soft lenses or sclera shells for use as corneal bandages when needed as a result of Surgery.
13. For therapeutic and elective abortions.
14. For Outpatient cardiac rehabilitation.
15. For Outpatient occupational therapy services.
16. For Routine Services, except as specified.
17. For a particular health service in the event that a Non-Contracting Provider waived Copayments, Coinsurance (and/or the Deductible per Benefit Period) no benefits are provided for the health service for which the Copayments, Coinsurance (and/or the Deductible per Benefit Period) are waived.
18. For non-covered services or services specifically excluded in the text of this Rider.

## ADDITIONAL GENERAL PROVISIONS

### How Claims are Paid

Medical Mutual, as the claims administrator, pays for benefits on behalf of the Plan for Covered Services through agreements with Contracting Institutional Providers and Participating Physicians and Other Professional Providers based on Negotiated Amounts. For Non-Contracting Institutional Providers, Medical Mutual pays for benefits based on

Non-Contracting Amount as determined by Medical Mutual. For Non-Participating Physicians and Other Professional Providers, Medical Mutual pays for benefits based on Traditional amounts.

### **Benefit Period Deductible**

Each Benefit Period, you must pay the dollar amount that may be specified in the Schedule of Benefits as the Deductible before 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 under this Rider. If a benefit is subject to a Deductible, only expenses for Covered Services under that benefit will satisfy the Deductible. To satisfy your Deductible, the Plan 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. Copayments will not apply to the Deductible. Deductibles do not apply to the Coinsurance Limit.

The Schedule of Benefits specifies a single Deductible and a family Deductible. The single Deductible is the amount each Covered Person must pay, but the total amount the family must pay is limited to the family Deductible.

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 Lesser Amount for Covered Services for all Covered Persons involved in the accident is at least equal to one Covered Person's Deductible.

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

### **Coinsurance**

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

If a Coinsurance Limit applies, the Schedule of Benefits may specify a single Coinsurance Limit and a family Coinsurance Limit. The single limit is the amount each Covered Person must pay, but the family limit is the total amount the family must pay based on the respective limits.

### **Copayments**

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

### **Schedule of Benefits**

The Deductible and Coinsurance Limit that may apply will renew each Benefit Period. Some of the benefits offered in this Benefit Book have maximums. In addition, there may be a lifetime maximum for all Covered Services listed in this Benefit Book.

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.

### **Your Financial Responsibility**

**You are responsible for paying Non-Covered Charges, Billed Charges for all services and supplies after benefit maximums have been reached, and for services and supplies rendered by Non-Contracting and Non-Participating Providers' Excess Charges.** Your financial responsibilities include the Deductible amounts specified in the Schedule of Benefits. Copayments and Coinsurance are also your responsibility. You are responsible for payment for services that are not Medically Necessary and for incidental charges.

# Multi-Language Interpreter Services & Nondiscrimination Notice



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

## Spanish

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

## Chinese

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

## German

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

## Arabic

ملحوظة: إذا كنت 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 nínizin: Díí saad bee yánílti' go Diné Bizaad, saad bee áká'ánida'áwo'déé', t'áá jiik'eh, éí ná hóló, kóijí' 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).

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.

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

**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](mailto: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](http://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](http://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.

