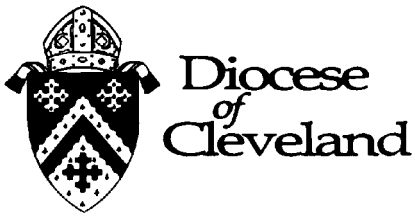

Religious

Group Number
228392 - 208

Health Care Benefit Book

NOTICE:

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

MEDICAL MUTUAL SERVICES, LLC

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

TABLE OF CONTENTS

amendmamm
amendnsahmoaso
STHMGNN-ASO5000/NGF
STHMGNN-OHS/NGF
STHMGNN-5000/NGF
STHEARRS
NSTA-ASO50003R
AMENDMENT MAMMOGRAM ASO 22
AMENDMENT ASO HMO NSA 22
NSTHMGNN-ASO5034
STHMGNN-ASO5033S/NGF
NSTHMGNN-ASO5034
NSTHEARR-ASO9000S

MEDICAL MUTUAL®

This Amendment modifies the coverage described in your Benefit Book and is effective on the first day of the Plan's next renewal date occurring on or after September 23, 2022. It is subject to all the terms and conditions of the Benefit Book. This Amendment terminates concurrently with the Benefit Book to which it is attached. Please place this Amendment with your Benefit Book for future reference.

1. The following definitions are added:
   a. **Screening Mammography** - a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening Mammography" includes digital breast tomosynthesis. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film. "Screening mammography" does not include diagnostic mammography.
   b. **Supplemental Breast Cancer Screening** - any additional screening method deemed medically necessary by a treating health care Provider for proper breast cancer screening in accordance with applicable American college of radiology guidelines, including magnetic resonance imaging, ultrasound, or molecular breast imaging.
2. The section for mammogram services within the Routine and Wellness Services or Preventive Services Health Care Benefit, as applicable, is deleted and replaced with the following:

   Mammogram services

   a. Screening Mammography for adult women
   b. Supplemental Breast Cancer Screening for adult women who meet either of the following conditions:
      1. The woman's Screening Mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman has dense breast tissue;
      2. The woman is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the woman's health care Provider.

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

IN WITNESS
WHEREOF:

Medical Mutual of Ohio

Patricia B. Decensi
Chief Legal Officer & Secretary

MEDICAL MUTUAL®

(HMO/EPO)

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

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

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

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

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

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

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

   b. The following definition is added:

      Independent Freestanding Emergency Department - a health care facility that:

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

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

   Emergency Services

   You are covered for Medically Necessary Emergency Services for an Emergency Medical Condition. Emergency Services are available 24 hours a day, 7 days a week, whether inside or outside the Service Area.

   In the event of an emergency:

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

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

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

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

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

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

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

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

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

      No Surprise Billing

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

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

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

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

b. The following provision is added:

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

If a Provider's contract with Medical Mutual ends:

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

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

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

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

   Serious and Complex Condition means:

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

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

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

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

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

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

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

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

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

IN WITNESS
WHEREOF:

Medical Mutual Services, LLC

Steven C. Glass
President & CEO

HEALTH CARE BENEFIT BOOK

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

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

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

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

This is not a summary plan description by itself. However, it may be attached to or included with a document prepared by your Group that is called a summary plan description.

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

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

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

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

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

SCHEDULE OF BENEFITS

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

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

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

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

HMO NETWORK MEDICAL BENEFIT	
Deductible per Benefit Period	
If you have single coverage:	$750
If you have family coverage:	$1,500
Coinsurance Limit per Benefit Period	
If you have single coverage:	$1,750
If you have family coverage:	$3,500
Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance, Prescription Drug is not administered by Medical Mutual)(1)	
If you have single coverage:	$2,500
If you have family coverage:	$5,000
Deductible and Out-of-Pocket Maximum Processing	Embedded (2)

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

BENEFIT MAXIMUMS PER COVERED PERSON	
(per Benefit Period unless otherwise shown)	
Autism Spectrum Disorders • Speech and Language Therapy • Occupational and Physical Therapy	 20 visits 40 visits (combined)
Chiropractic/Spinal Manipulation Visits	24 visits
Home Health Care Services	100 visits
Inpatient Hospital Days (except Skilled Nursing Facility Services)	365 days per confinement (3)
Outpatient Cardiac Rehabilitation Services	20 visits
Outpatient Occupational and Physical Therapy Services	40 visits (combined)
Outpatient Pulmonary Therapy Services	20 visits
Outpatient Speech Therapy Services	20 visits
Routine Mammogram Services	One mammogram; limited to 130% of the Medicare reimbursement amount; the maximum reimbursement amount applies only to Covered Services received inside the state of Ohio, as mandated by the state of Ohio.
Skilled Nursing Facility Services	120 days
Wigs	One wig

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

COINSURANCE AND COPAYMENTS FOR INSTITUTIONAL AND PROFESSIONAL CHARGES	
TYPE OF SERVICE	**For Covered Services received from an HMO Network Provider, You pay the following portion, based on the Allowed Amount**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.	
EMERGENCY ROOM SERVICES	
The Institutional charge for use of the Emergency Room in an Emergency	$150 Copayment, waived if admitted, not subject to the Deductible
Emergency Room Physician's Charges in an Emergency	20%
All other related charges in an Emergency	20%
The Institutional charge for use of the Emergency Room in a **non-emergency**	$500 Copayment, waived if admitted, then 40%
Emergency Room Physician's Charges in a **non-emergency**	40%
All other related Charges in a **non-emergency**	Any applicable Deductible, Out-of-Pocket Maximum or Copayment corresponds to the type of service received.
INPATIENT SERVICES	
Semi-Private Room and Board	20%
Physical Medicine and Rehabilitation	20%
Maternity	20%
Newborn Care	20%
Skilled Nursing Facility	20%
MENTAL HEALTH CARE, DRUG ABUSE AND ALCOHOLISM SERVICES	
Mental Health Care, Drug Abuse and Alcoholism Services	Any applicable Deductible, Out-of-Pocket Maximum or Copayment corresponds to the type of service received and is payable on the same basis as any other illness (e.g., emergency room visits for a Mental Illness will be paid according to the Emergency Services section above).
OUTPATIENT REHABILITATIVE SERVICES	
Cardiac Rehabilitation Services	20%
Chiropractic Services	20%
Occupational and Physical Therapy Services	20%
Respiratory/Pulmonary Therapy Services	20%
Speech Therapy Services	20%
PHYSICIAN/OFFICE SERVICES	
Certain Immunizations not covered under PPACA (4)	0%, not subject to the Deductible
Medically Necessary Office Visits (5)	$20 Copayment, not subject to the Deductible
Medically Necessary Office Visits in a Specialist's Office	$40 Copayment, not subject to the Deductible
Urgent Care Office Visits	$25 Copayment, not subject to the Deductible
ROUTINE, PREVENTIVE AND WELLNESS SERVICES	
Preventive Services in accordance with state and federal law (6)	0%, not subject to the Deductible
Colonoscopy and Sigmoidoscopy (Ages 40-75)	0%, not subject to the Deductible
Anoscopy and Proctosigmoidoscopy and Routine Colonoscopy and Sigmoidoscopy (other than ages 40-75)	0%, not subject to the Deductible

COINSURANCE AND COPAYMENTS FOR INSTITUTIONAL AND PROFESSIONAL CHARGES	
TYPE OF SERVICE	**For Covered Services received from an HMO Network Provider, You pay the following portion, based on the Allowed Amount**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.	
Laboratory, X-ray and Medical Testing Services	0%, not subject to the Deductible
SURGICAL SERVICES	
Inpatient Surgery	20%
Medically Necessary Endoscopic Procedures (i.e, Colonoscopy, Sigmoidoscopy, etc.)	20%
Outpatient Surgery	20%
OTHER SERVICES	
Hospice Services	0%, not subject to the Deductible
Outpatient Diabetic Education and Training and Medical Nutrition Therapy Services	0%, not subject to the Deductible
All Other Covered Services	20%

Notes

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

1. Prescription Drug benefits that accumulate toward the Out-of-Pocket Maximum are provided under a separate arrangement between the Group and the Group's pharmacy benefits manager and are not part of this Plan administered by Medical Mutual.
2. "Embedded processing" - A family plan with two kinds of Deductibles and Out-of-Pocket Maximums: one for an individual family member and one for the whole family. With family coverage, each Covered Person's Out-of-Maximum will not exceed the Out-of-Pocket Maximum for single coverage shown on the Schedule of Benefits.
3. All confinements must be separated by 60 consecutive days in order to renew benefit. Any days in a Skilled Nursing Facility approved by Case Management are separate from the Benefit Period Maximums shown.
4. Contact Customer Care for more details.
5. Includes Office Visits to a Psychiatrist or Psychologist, Licensed Independent Social Worker, Licensed Professional Clinical Counselor, and Licensed Marriage-Family Therapist.
6. Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

HOW TO USE YOUR BENEFIT BOOK

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

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

Benefit Book - this document.

Benefit Period - the period of time specified in the Schedule of Benefits during which Covered Services are rendered, and benefit maximums, Deductibles, Coinsurance Limits and Out-of-Pocket Maximums are accumulated. The first and/or last Benefit Periods may be less than 12 months depending on the Effective Date and the date your coverage terminates.

Billed Charges - the amount billed on the claim submitted by the Provider for services and supplies provided to a Covered Person.

Biosimilar Prescription Drug - a Prescription Drug that:

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

Card Holder - an eligible member of the Group who has enrolled for coverage under the terms and conditions of the Plan and persons continuing coverage pursuant to any 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.

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

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

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

Confinement Period - the period of time beginning when you enter a Hospital or Other Facility Provider, not including a Skilled Nursing Facility, as an Inpatient and ending when you have been out of the Hospital or facility for 60 days.

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

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

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

Covered Charges - the Billed Charges for Covered Services received from a Medical Mutual HMO Network Provider.

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

Covered Service - a Provider's service or supply as described in this Benefit Book for which the Plan will provide benefits, as listed in the Schedule of Benefits.

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

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

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

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

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

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

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

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

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

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

Essential Health Benefits - benefits defined under federal law (PPACA) as including benefits in at least the following categories; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health

and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Refer to the Schedule of Benefits and the Health Care Benefits section of this Benefit Book to identify which of these Essential Health Benefits are included in this plan.

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

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

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

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

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

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

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

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

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

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 (must be of the opposite sex), parents, stepparents, grandparents, nieces, nephews, aunts, uncles, cousins, brothers, sisters, children and stepchildren by blood, marriage or adoption.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Alcoholism Treatment Facility -** a facility that mainly provides detoxification and/or rehabilitation treatment for Alcoholism.
- **Ambulatory Surgical Facility -** a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a Physician and also includes nursing services.

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

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

- advanced nurse practitioner (A.N.P.);
- ambulance services;
- certified dietician;
- certified nurse practitioner;
- clinical nurse specialist;
- dentist;
- doctor of chiropractic medicine;
- durable medical equipment or prosthetic appliance vendor;
- laboratory (must be Medicare Approved);
- licensed independent social workers (L.I.S.W.);
- licensed practical nurse (L.P.N.);
- licensed professional clinical counselor;
- licensed professional counselor;
- licensed vocational nurse (L.V.N.);
- mechanotherapist (licensed or certified prior to November 3, 1975);
- nurse-midwife;
- occupational therapist;
- ophthalmologist;
- optometrist;
- osteopath;
- Pharmacy;
- physical therapist;
- physician assistant;
- podiatrist;
- Psychologist;

- registered nurse (R.N.);
- registered nurse anesthetist; and
- Urgent Care Provider.

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

Out-of-Pocket Maximum - a specified dollar amount of Deductible, Coinsurance and Copayment expense Incurred in a Benefit Period by a Covered Person for Covered Services.

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

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

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

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

PPACA - Patient Protection and Affordable Care Act

Preauthorization - A decision by Medical Mutual that a health care service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. This is also referred to as "precertification" or "prior approval". Medical Mutual requires Preauthorization before you are admitted as an Inpatient in a Hospital or before you receive certain services, except for an Emergency Medical Condition. Preauthorization is not a promise that the Plan will cover the cost.

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

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

Primary Care Physician - a Physician or group of Physicians, advanced nurse practitioners trained in family or general practice, geriatrics, internal medicine, obstetrics/gynecology or neonatology/pediatric medicine who has a contractual obligation with Medical Mutual to provide the primary care services of this plan and who may request Medical Mutual to authorize Covered Services from Non-Network Providers.

Professional - a Physician or Other Professional Provider.

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

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

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

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

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

Rider - a document that amends or supplements your coverage.

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

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

- registered nurse;

- licensed practical nurse; or
- physical therapist

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

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

Specialty Prescription Drugs - A Prescription Drug that:

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

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

Substance Abuse - Alcoholism and/or Drug Abuse.

Surgery -

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

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

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

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

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

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

ELIGIBILITY

Enrolling for Coverage

Prior to receiving this Benefit Book, you enrolled for individual coverage. For coverage, you completed an Enrollment Form. There may be occasions when the information on the Enrollment Form is not enough. The Plan will then request the additional data needed to determine whether you are eligible.

Under individual coverage, only the Card Holder is covered.

Eligibility

Only the following persons may be Eligible Persons under this Benefit Book:

(a) Active members of Catholic Orders and persons preparing to take religious vows of Catholic Orders which have adopted the program on behalf of their members.

(b) Card Holders who are entitled to continuation of coverage under the terms of the Plan, who make elections within the grace periods specified in the Plan, and who continue to make the required contributions in a timely manner.

(c) A Card Holder who ceases to be an active Member of the Catholic Order because of a total and permanent disability. For purposes of this section, the term "total and permanent disability" shall mean any disability which continuously disables and wholly prevents an individual from being able to engage in any regular gainful employment or occupation, excluding any disability which was (a) contracted, suffered, or incurred while the individual was engaged in, or resulted from his having engaged in a criminal act or enterprise, or (b) resulted from his habitual drunkenness or addiction to narcotics or use of hallucinogens, or (c) resulted from an intentionally self-inflicted injury.

(d) A Card Holder who ceases to be an active Member of a Catholic Order upon retirement from active service with such Order, provided that such Card Holder shall have been an active Member of the Catholic Order and covered by a medical plan maintained by the Diocese of Cleveland for at least five years. For purposes of this section, "retirement" shall mean ceasing to be in active service for the Catholic Order following attainment of age fifty-five (55).

Effective Date

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

Changes in Coverage

Generally, you may only change or revoke your benefit election during each year's Open Enrollment Period by providing written notice to the Administrator in a form acceptable to the Administrator. Open Enrollment Periods occur in April and May, with elections becoming effective on the following July 1st. Any such election may not be changed or revoked until the next Open Enrollment Period. However, if you have a change in status, you may revoke your previous election during a Period of Coverage and make a new election for the remaining portion of the period if the revocation and new election result from a change in status and are consistent with such change in status. All changes in status must be reported to the plan administrator within 31 days of the event so as not to adversely affect eligibility for coverage.

It is important to complete and submit your application promptly as the date this new coverage begins will depend on when you apply.

There are occasions when circumstances change. The Plan Sponsor must be notified when you become eligible for Medicare.

Additional Events Added Allowing a Participant to Revoke a Health Care Plan Election

There are two additional limited circumstances for which an employee participating in the Diocese Health Care Plans may revoke his or her health care plan election (*but not an FSA election*) during the plan year. The IRS has added these additional permitted circumstances because of changes made by the Affordable Care Act ("ACA") Employer Shared Responsibility rules which affect some Participating Employers under the Diocese Health Care Plans.

1. An employee of an Applicable Large Employer under the ACA who has a change in employment status from full-time to part-time, but continues to be treated as full-time because of the stability period

   An employee who has a change in employment status from full-time to part-time, but continues to be treated as full-time during the stability period, may elect to revoke his or her Health Care Plan election (*but not an FSA election*) prospectively and drop his or her medical plan coverage *only if*:

   - Such employee had been reasonably expected to work on average 30 hours or more per week as a full-time employee and, after the change to part-time, such employee is reasonably expected to work on average less than 30 hours per week, but because of the ACA rules continues to be treated as full-time for purposes of the Health Care Plan; *and*
   - Such employee signs a representation that he or she has either already enrolled in, or intends to enroll in, other healthcare coverage which provides minimum essential coverage for himself or herself (and any dependents if he or she had elected family coverage) effective no later than the first day of the second month after the month in which the Diocesan Health Care Plan coverage is revoked.

   Other minimum essential healthcare coverage might be provided under another employer's healthcare plan, a spouse's healthcare plan, or a government program including Medicare or Medicaid. It is suggested that an employee check eligibility and effective date for enrollment in other coverage when considering revoking his or her Diocesan Health Care Plan election. Note that generally enrollment in the Marketplace Exchange would not be available unless it coincides with the Marketplace open enrollment, or the circumstances meet the Marketplace Exchange special enrollment rights. Any revocation of the Diocesan Health Care Plan election is effective on a prospective basis only and must be submitted timely.

2. Marketplace Exchange Open Enrollment

   Any participant may elect to revoke his or her Diocesan Health Care Plan election (*but not an FSA election*) prospectively in order to enroll in a Qualified Plan through the Marketplace Exchange either because of a Special Enrollment Period or during the Marketplace Exchange open enrollment period. The Marketplace Exchange open enrollment period typically starts in November of each year for health care coverage effective starting the following January 1. The Diocesan Health Care Plan coverage would remain in effect through to the day before the Marketplace Exchange coverage takes effect. In the case of the open enrollment period, the Diocesan Health Care Plan coverage would remain in effect through December and the Marketplace Qualified Plan would be effective immediately thereafter on January 1. In the event the employee revokes his or her election for family coverage, his or her dependents must also be enrolled in a Qualified Plan.

   Generally, the Diocesan Health Care Plan coverage is affordable minimum essential coverage, consequently an election to drop it in order to obtain coverage in a Qualified Plan through the Marketplace Exchange most likely would not entitle an employee to receive the tax credit subsidy.

Special Enrollment

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

1. In order to qualify for special enrollment rights because of loss of coverage, you or your Eligible Dependent must have had other group health plan coverage at the time coverage under this Benefit Book was previously offered. You or your Eligible Dependent must have also stated, in writing, at that time that coverage was declined because of the other coverage, but only if Medical Mutual required such a statement at the time coverage was declined, and you were notified of this requirement and the consequences of declining coverage at that time.
2. If coverage was non-COBRA, loss of eligibility or the Group's contributions must end. A loss of eligibility for special enrollment includes:
   a. Loss of eligibility for coverage as a result of legal separation or divorce
   b. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Benefit Book)
   c. Death of an Eligible Employee
   d. Termination of employment
   e. Reduction in the number of hours of employment that results in a loss of eligibility for plan participation (including a strike, layoff or lock-out)

f. Loss of coverage that was one of multiple health insurance plans offered by an employer, and the Eligible Employee elects a different plan during an open enrollment period
g. An individual no longer resides, lives, or works in an HMO Service Area (whether or not within the choice of the individual), and no other benefit package is available to the individual through the other employer
h. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual
i. A situation in which an individual incurs a claim that would meet or exceed a medical plan lifetime limit on all benefits (additional requirements apply)
j. Termination of an employee's or dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)
k. The employee or dependent is determined to be eligible for premium assistance in the Group's plan under a Medicaid or CHIP plan

3. Enrollment must be supported by written documentation of the termination of the other coverage with the effective date of said termination stated therein. With the exception of items "j" (termination of Medicaid or CHIP coverage) and "k" (eligibility for premium assistance) above, notice of intent to enroll must be provided to Medical Mutual by the Group no later than thirty-one (31) days following the triggering event with coverage to become effective on the date the other coverage terminated. For items "j" and "k" above, notice of intent to enroll must be provided to Medical Mutual by the Group within sixty (60) days following the triggering event, with coverage to become effective on the date of the qualifying event.

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

Termination of Coverage

- Coverage ceases on the last day of the month in which a Card Holder no longer meets the requirements for eligibility, regardless of whether such individual is eligible for accrued vacation pay upon termination. That is, a Covered Person's eligibility for benefits under this Plan will not be automatically extended for the durational equivalent of such Covered Person's accrued vacation pay, if any. Similarly, Covered Persons who are normally employed by the Diocese for less than twelve (12) months per year (such as teachers), but who have elected to receive their regular wages proportionately reduced throughout a twelve (12) month period shall not be entitled to extended coverage under this Plan upon their termination of employment solely as a result of their special pay arrangements.
- Termination of the Group Agreement automatically ends all of your coverage and you are not offered a conversion privilege. It is the responsibility of your Group to tell you of such termination.
- We have the right to void the coverage of any Covered Person who engages in fraudulent conduct, deception or misrepresentation relating to claims, application for coverage, obtaining benefits or the use of an Identification Card.

If your Group coverage would otherwise end, you may be eligible for continuation of benefits.

You may also be eligible for additional continuation of coverage under state or federal law.

Your Group's benefits administrator can coordinate your continuation of coverage with us. To obtain specific details and to arrange for continuation of Group health care benefits, contact your Group's benefits administrator as soon as possible.

Your Identification Card

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

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

HEALTH CARE BENEFITS

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

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

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

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

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

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

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

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

Women's Health and Cancer Rights Act Notice

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

Alcoholism and Drug Abuse Services

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

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

Inpatient admissions to a Hospital Provider or Residential Treatment Facility Provider must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Network Hospitals in Ohio will assure this preauthorization is done; and since the Hospital is responsible for obtaining the preauthorization, there is no penalty to you if this is not done.

Allergy Tests and Treatments

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

Ambulance Services

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

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

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

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

Transportation services provided by an ambulette or a wheelchair van are not Covered Services.

Autism Spectrum Disorders

Benefits are payable for the screening, diagnosis, and treatment of autism spectrum disorders.

Covered Services include:

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

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

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

Case Management

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

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

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

Clinical Trial Programs

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

In order to be eligible for benefits, the Covered Person must meet the following conditions:

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

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

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

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

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

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

No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the Approved Clinical Trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the Approved Clinical Trial;
- An item or drug provided by the Approved Clinical Trial sponsors free of charge for any patient;

- A service, item, or drug that is eligible for reimbursement by an entity other than Medical Mutual, including the sponsor of the Approved Clinical Trial;
- A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Dental Services for an Accidental Injury

Dental services will only be covered for 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.

Diagnostic Services

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

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

Drugs and Biologicals

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

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

Specialty Prescription Drugs require prior approval from Medical Mutual.

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

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

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

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

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

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

Emergency Services

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

In the event of an Emergency:

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

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

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

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

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

Health Education Services

Behavioral Counseling to Promote a Healthy Diet - Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases.

Home Health Care Services

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

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

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

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

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

Hospice Services

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

The following Covered Services are considered hospice services:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- Prescription Drugs; limited to a two-week supply per Prescription Drug Order or refill (These Prescription Drugs must be required in order to relieve the symptoms of a Condition, or to provide supportive care.);
- oxygen and its administration;
- medical social services, such as the counseling of patients;
- home health aide visits when you are also receiving covered nursing or therapy services;
- acute Inpatient hospice services;
- respite care;
- dietary guidance; counseling and training needed for a proper dietary program;
- durable medical equipment; and
- bereavement counseling for family members.

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

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

Inpatient Hospital Services

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

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

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

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

- operating, delivery and treatment rooms and equipment;
- Prescription Drugs;

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

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

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

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

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

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

Inpatient admissions to a Hospital must be Preauthorized. The telephone number for Preauthorization is listed on the back of your identification card. Network Hospitals in Ohio will assure this Preauthorization is done; and since the Hospital is responsible for obtaining the Preauthorization, there is no penalty to you if this is not done. If your Inpatient stay is for an organ transplant, please review the requirements under the Organ Transplant Services section.

Inpatient Physical Medicine and Rehabilitation Services

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

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

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

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

Physician-directed, follow-up care services are covered after discharge including:

- parent education;

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

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

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

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

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of Inpatient care required to be covered, at home post delivery follow up care visits are covered for you at your residence by a Physician or nurse when performed no later than 72 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

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

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

Medical Care

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

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

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

Staff consultations required by Hospital rules are not covered.

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

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

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

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

Office Visits

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

Medical Supplies and Durable Medical Equipment

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

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

- syringes
- needles
- oxygen
- diabetic supplies;
- surgical dressings and other similar items; and
- Jobst stockings and support/compression stockings.

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

- **elastic bandages;**
- **thermometers; and**
- **corn and bunion pads.**

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

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

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

Covered DME includes:

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

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

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

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

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

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

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

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

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

Covered prosthetic appliances include:

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

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

- **dentures, unless as a necessary part of a covered prosthesis;**
- **dental appliances;**

- **eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye;**
- **replacement of cataract lenses unless needed because of a lens prescription change;**
- **taxes included in the purchase of a covered prosthetic appliance;**
- **deluxe prosthetics that are specially designed for uses such as sporting events.**

Mental Health Care Services

Covered Services for the treatment of Mental Illness include:

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

Services for learning disabilites, other than those necessary to evaluate or diagnose these Conditions, are not covered. Services for the treatment of attention deficit disorder are covered.

Inpatient admissions to a Hospital Provider or Residential Treatment Facility Provider must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Network Providers in Ohio will assure this preauthorization is done; and since the Provider is responsible for obtaining the preauthorization, there is no penalty to you if this is not done.

Organ Transplant Services

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

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

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

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

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

- the proposed course of treatment for the transplant;
- the name and location of the proposed transplant center; and

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

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

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

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

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

The Plan does not provide organ transplant benefits for services, supplies or Charges:

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

Other Outpatient Services

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

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

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

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

Outpatient Institutional Services

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

Covered Institutional services include, but are not limited to:

- operating, delivery and treatment rooms and equipment;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. The Plan will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded.
- anesthesia, anesthesia supplies and services; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

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

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

Outpatient Rehabilitative Services

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

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

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

Medical Nutrition Therapy - The assessment of nutrition status followed by nutritional therapy. Nutritional therapy may include diet modification, counseling and education, disease self-management skills training and administration of special therapy such as medical foods, intravenous or tube feedings.

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

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

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

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

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

Speech Therapy - In order to be considered a Covered Service, this therapy must be performed by a certified, licensed therapist and be Medically Necessary due to a medical Condition such as:

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

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

Preventive and Wellness Services

PPACA and Ohio Preventive Services

Gynecological Services -

- mammogram services; and
- PAP tests.

Health Education Services -

- Behavioral Counseling to Promote a Healthy Diet - Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases.
- Diabetic Self-Management Training and Education Services - are Covered Services when provided under the supervision of a licensed health care professional with expertise in diabetes. These services help to ensure that

persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diet and medical nutrition therapy.

Immunizations - Immunizations are covered.

Physical Examinations - Physical examinations are covered.

Other Services - The following services are covered:

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

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

Well child care services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination, routine newborn hearing screening and developmental assessment. Vision tests, hearing tests and the developmental assessment must be included as part of the physical examination in order to be provided as part of this benefit. This review also includes anticipatory guidance, laboratory tests and appropriate immunizations.

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

Additional Preventive Services

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

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

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

Additional Preventive and Wellness Services

The following services are covered:

- laboratory;

- x-rays;
- medical testing.

Private Duty Nursing Services

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

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

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

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

Skilled Nursing Facility Services

The benefits available to an Inpatient of a Hospital listed under the Inpatient Hospital Services section are also available to an Inpatient of a Skilled Nursing Facility. These services must be Skilled Care authorized by Medical Mutual. All Covered Services will be provided according to your Physician's treatment plan and as authorized by Medical Mutual.

No benefits are provided:

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

Smoking Cessation Services

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

Surgical Services

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

- removal of bony impacted teeth;
- maxillary or mandibular frenectomy;
- mandibular staple implant. This is not a Covered Service when performed to prepare the mouth for prosthetics;
- diagnostic endoscopic procedures, such as colonoscopy and sigmoidoscopy;
- reconstructive Surgery following a mastectomy, including coverage for reconstructive Surgery performed on a non-diseased breast to establish symmetry as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas;
- Surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes as determined by Medical Mutual, subject to any appeal process. **Surgery to**

correct a deformity or birth defect for psychological reasons, where there is no functional impairment, is not covered.

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

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

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

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

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

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

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

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

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

Temporomandibular Joint Syndrome Services

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

Urgent Care Services

Health problems that require immediate attention which are not Emergency Medical Conditions are considered to be Urgent Care needs. Determination as to whether or not Urgent Care Services are Medically Necessary will be made by Medical Mutual.

Examples of Urgent Care are:

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

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

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

EXCLUSIONS

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

1. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
2. Not performed within the scope of the Provider's license.
3. Not Medically Necessary or do not meet Medical Mutual's policy, clinical coverage guidelines, or benefit policy guidelines.
4. Received from other than a HMO Network Provider, except for an Emergency Medical Condition, or as specified.
5. Received from other than a Provider.
6. Inpatient and Outpatient Medical Care at children's Hospital facilities for Covered Persons age twenty (20) and above, except in the event of an Emergency Medical Condition, or upon the determination that Medical Care from a children's Hospital Inpatient or Outpatient Provider is Medically Necessary.
7. For Experimental or Investigational drugs, devices, medical treatments or procedures, except as specified.
8. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
9. For a Condition that occurs as a result of any act of war, declared or undeclared.
10. For a Condition resulting from direct participation in a riot, civil disobedience, nuclear explosion or nuclear accident.
11. For which you have no legal obligation to pay in the absence of this or like coverage.
12. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
13. Received from a member of your Immediate Family.
14. Incurred after you stop being a Covered Person except as specified in the Benefits After Termination of Coverage section.
15. For the following:
    - physical examinations or services required by an insurance company to obtain insurance;
    - physical examinations or services required by a governmental agency such as the FAA and DOT;
    - physical examinations or services required by an employer in order to begin or to continue working;
    - premarital examinations.
16. For X-ray examinations with no preserved film image or digital record.
17. For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability or similar laws, even when the Covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.
18. For which benefits are payable under Medicare Part B or would have been payable if a Covered Person had applied for Part B, except, as specified elsewhere in this Benefit Book or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Part B, Medical Mutual will calculate benefits as if he or she had enrolled.
19. Received in a military facility for a military service related Condition.
20. For court-ordered testing or care unless Medically Necessary.
21. For Surgery and other services primarily to improve appearance (including removal of tattoos) or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss Surgery), except as specified. This exclusion does not apply to medical complications directly related to such Surgery or other services.
22. For Surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment.
23. For weight loss Surgery and any repairs, revisions or modifications of such Surgery, including weight loss device removal, unless determined by Medical Mutual to be a Covered Service in accordance with Medical Mutual's corporate

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

24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss or obesity, unless otherwise specified.
25. For dietary and/or nutritional counseling or training, except as specified or required by PPACA.
26. For nutritional supplements.
27. For treatment of learning disabilities, other than treatment necessary to evaluate or diagnose these Conditions.
28. For educational services, including special education and remedial education, vocational services, recreational services, other non-clinical services, or services provided for training purposes, except as may be required by PPACA.
29. For marital counseling.
30. For the medical treatment of sexual problems not caused by a biological Condition.
31. For gender affirming Surgery, or any treatment leading to or in connection with gender affirming Surgery.
32. For Contraceptives and over-the-counter birth control devices.
33. For Contraceptive devices, which include, but are not limited to, IUD's, diaphragms and cervical caps.
34. For sterilizations, except to remove a pathological Condition that threatens the life or physical Condition of the patient and reversals of sterilization.
35. For abortions, unless the pregnancy would endanger the life of the mother.
36. For treatment of infertility, including, but not limited to, artificial insemination, in vitro fertilization, Gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT).
37. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.
38. For dental implants, considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic, except as described in the "Dental Services for an Accidental Injury" benefit.
39. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery.
40. For dental care, except for the removal of cysts, granulomas, tumors and horizontal impactions and except for the repair or relief of injuries to natural teeth resulting from an accident which occurred while the individual was a Covered Person.
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 or contact lenses, except as described in the section entitled "Prosthetic Appliances" under the "Medical Supplies and Durable Medical Equipment" benefit.
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), unless otherwise specified.
46. For hearing aids.
47. For massotherapy or massage therapy.
48. For hypnosis and acupuncture.
49. For blood which is available without charge. For Outpatient blood storage services.
50. For the services of blood donors.
51. For Prescription Drugs, unless otherwise specified.
52. For over the counter drugs, vitamins or herbal remedies, except for certain preventive drugs written with a Physician's prescription and required by PPACA.
53. 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.
54. For specialized camps.
55. For wilderness therapy, therapeutic living communities (including therapeutic farms), adventure-based therapy or similar programs.
56. For water aerobics.
57. For missed appointments, completion of claim forms or copies of medical records.

58. For telephone consultations or consultations via electronic mail, facsimile or internet/website, except as required by law, authorized by Medical Mutual, or as otherwise described in this Benefit Book.
59. For stand-by charges of a Physician.
60. For any Charges not documented in Provider records.
61. For fraudulent or misrepresented claims.
62. For charges for doing research with Providers not directly responsible for your care.
63. For non-Covered Services or services specifically excluded in the text of this Benefit Book.

GENERAL PROVISIONS

How to Apply for Benefits

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

Notice of Claim; Claim Forms

A claim must be filed for you to receive benefits. HMO Network Providers and many Non-HMO Network Providers will submit a claim for you; if in the event you need to submit a claim from a Non-HMO Network Provider or for a Prescription Drug claim, you should use a claim form. In most cases, you can obtain a claim form from your Group or Provider. If your Provider does not have a claim form, Medical Mutual will send you one. Call or notify Medical Mutual, in writing, within 20 days after receiving your first Covered Service and we will send you a form, or you may print a claim form by going to www.medmutual.com/member.

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

Proof of Loss

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

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

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

How Claims are Paid

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

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

Your Financial Responsibilities

You are responsible for:

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

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

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

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

Benefit Period Deductible

Each Benefit Period, you must pay the dollar amount that is shown in the Schedule of Benefits as the Deductible, if applicable, before the Plan will begin to provide benefits. This is the amount of expense that must be Incurred and paid by you for Covered Services before the Plan starts to provide benefits. If a benefit is subject to a Deductible, only expenses for Covered Services under that benefit will satisfy the Deductible. To satisfy your Deductible, Medical Mutual records must show that you have Incurred claims totaling the specified dollar amount, so submit copies of all your bills for Covered Services. Your Deductible accumulations do not necessarily occur in the same order that you receive services, but in the order in which Medical Mutual receives and processes your claims.

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

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

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

Coinsurance

After you meet any applicable Deductible, you may be responsible for Coinsurance amounts as specified in your Schedule of Benefits.

Copayments

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

Out-of-Pocket Maximum

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

Schedule of Benefits

The Deductible(s) and Out-of-Pocket Maximums that may apply will renew each Benefit Period. Some of the benefits offered in this Benefit Book have maximums.

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

Provider Status and Direction of Payment

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

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

After a Provider performs a Covered Service, Medical Mutual will not honor your request to withhold claim payment. Medical Mutual does not furnish Covered Services but only pays for Covered Services you receive from Providers. Medical Mutual is not liable for any act or omission of any Provider.

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

Medical Mutual is authorized to make payments directly to Providers who have performed Covered Services for you. Medical Mutual also reserves the right in some circumstances to make payment directly to you in the event you receive Covered Services from a Non-HMO Network Provider. When this occurs, you must pay the Provider the amounts you may owe to the Provider. You cannot assign your right to receive payment to anyone else, nor can you authorize someone else to receive your payments for you, including your Provider.

If Medical Mutual has incorrectly paid for non-covered services, or it is later discovered that payment was made for services that are not considered Covered Services, Medical Mutual has the right to recover payment from the Provider on the behalf of the Group, and you must pay the Billed Charges amount to the Provider when requested.

Prior Approval of Non-Network Benefits

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

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

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

Medical Mutual will determine whether the Covered Services can be provided by a HMO Network Provider, and that determination will be final and conclusive, subject to any available appeals process. Medical Mutual may elect to have you examined by a Physician of its choice and will pay for any related physical exams required. You and your Physician will be notified if Covered Services provided by a Non-HMO Network Provider will be covered as if they had been provided by a HMO Network Provider. If you do not receive written approval in advance of receiving services from a Non-HMO Network Provider, no benefits will be provided, except for an Emergency Medical Condition.

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Physician

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

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

Explanation of Benefits

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

Time of Payment of Claims

Benefits will be provided under this Benefit Book within 30 days after receipt of a completed claim. If supporting documentation is required, then payment will be made in accordance with state and federal law. To have a payment or denial related to a claim reviewed, you must send a written request or call Customer Service at Medical Mutual within 180 days of the claim determination.

Foreign Travel

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

To receive reimbursement for Hospital and/or medical expenses, the services rendered must be eligible for coverage in accordance with the benefits described in this Benefit Book. If you travel to a foreign country and you receive treatment for an Emergency Medical Condition from a Non-HMO Network Provider, Medical Mutual will provide coverage at the same level of benefits as a HMO Network Provider.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of Medical Mutual, Medical Mutual will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of Medical Mutual, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of Medical Mutual, disability affecting a significant number of a HMO Network Provider's staff or similar causes, or health care services provided under this Benefit Book are delayed or considered impractical. Under such circumstances, Medical Mutual and HMO Network Providers will provide the health care services covered by this Benefit Book as far as is practical under the circumstances, and according to their best judgment. However, Medical Mutual and HMO Network Providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of Medical Mutual.

Filing a Complaint

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

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

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

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

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

Benefit Determination for Claims

Claims Involving Urgent Care

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

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

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

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

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

Concurrent Care Claims

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

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

Pre-Service Claims

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

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

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

Post-Service Claims

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

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

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

Adverse Benefit Determination Notices

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

- the specific reason(s) for the adverse benefit determination;
- reference to the specific plan provision(s) on which the adverse benefit determination is based;
- sufficient information to identify the claim or health care service involved, including the date of services, the health care provider, and the claim amount, if applicable;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of Medical Mutual's appeal procedures and applicable timeframes, including the expedited appeal process, if applicable;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the adverse benefit determination was based on Medical Necessity, Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

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

Filing an Appeal

If you are not satisfied with any of the following:

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

then you may file an appeal.

To submit an appeal electronically, go to Medical Mutual's Web site, www.MedMutual.com, under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card for more information about how to file an appeal. You may also write a letter with the following information: Card Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, documents, dental X-rays or photographs you would like considered in the appeal. Send or fax the letter and records to:

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

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

Mandatory Internal Appeal

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

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

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

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

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

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

You will receive continued coverage pending the outcome of the appeals process. For this purpose, Medical Mutual may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review.

The appeal procedures are as follows:

Appeal of a Claim Involving Urgent Care

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

Pre-Service Claim Appeal

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

Post-Service Claim Appeal

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

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

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

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

External Review Process

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

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

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

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

External Review for Non-Urgent Care Claim Appeals

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

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

Expedited External Review for Urgent Care Claim Appeals

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

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

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

Voluntary Internal Review Process

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

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

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

Claim Review

Consent to Release Medical Information - Denial of Coverage

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

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

Right to Review Claims

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

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

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

Physical Examination

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

Legal Actions

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

Coordination of Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

Definitions

1. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   a. **Plan** includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
   b. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under "a" or "b" above is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.
2. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.
3. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

   When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.
4. **Allowable expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an **Allowable expense**.

   The following are examples of expenses that are not **Allowable expenses**:
   a. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private Hospital room expenses.
   b. If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
   c. If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
   d. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the Provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
   e. The amount of any benefit reduction by the **Primary plan** because a Covered Person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, preauthorization of admissions, and preferred provider arrangements.
5. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.

6. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order Of Benefit Determination Rules

When a person is covered by two or more **Plans** , the rules for determining the order of benefit payments are as follows:

1. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.
2. a. Except as provided in Paragraph "b" below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.
   b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
3. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
4. Each **Plan** determines its order of benefits using the first of the following rules that apply:
   a. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.
   b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order of benefits is determined as follows:
      1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
         - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
         - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.
         - However, if one parent's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
      2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
         b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
         c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
         d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            - The **Plan** covering the **Custodial parent**;
            - The **Plan** covering the spouse of the **Custodial parent**;
            - The **Plan** covering the **non-custodial parent**; and then
            - The **Plan** covering the spouse of the **non-custodial parent**.

3. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c. Active employee or retired or laid-off employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

d. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

e. Longer or shorter length of coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

f. If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

Effect On The Benefits Of This Plan

1. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
2. If a Covered Person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. Medical Mutual may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. Medical Mutual need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Medical Mutual any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Medical Mutual may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. Medical Mutual will not have to pay that amount again. The term " payment made " includes providing benefits in the form of services, in which case " payment made " means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Medical Mutual is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should attempt to resolve the problem by contacting Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card.

Right of Subrogation and Reimbursement

Subrogation

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

Reimbursement

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

Your Duties

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

Discretionary Authority

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

Changes In Benefits or Provisions

The Diocese may amend the Plan at any time as evidenced by an instrument, in writing, executed in the name of the Diocese by a duly authorized representative. Any such amendment may be made retroactively effective and will be binding upon the Card Holders, except that no such amendment will retroactively deprive a Card Holder or Eligible Dependent of a benefit under the Plan. No change in the Agreement relating to the Plan will be effective until approved, in writing, by an authorized officer of Medical Mutual and the Catholic Diocese of Cleveland. This approval must be endorsed on or attached to the Agreement. No agent, employee or representative of Medical Mutual, other than an authorized officer, may change the Agreement or waive any of its provisions.

It is the intention of the Diocese to continue the Plan indefinitely. However, the Diocese reserves the right to terminate the Plan at any time as evidenced in writing, executed in the name of the Diocese by a duly authorized representative.

Termination of Coverage

How and When Your Coverage Stops

Your coverage stops:

- By termination of the Agreement with Medical Mutual including termination for non-payment. This automatically ends all of your coverage and you are not offered a conversion privilege. It is the responsibility of your Group to notify you of such termination.
- On the date that a Card Holder becomes ineligible.
- At the end of the period for which payment was made when a Covered Person does not pay the required contribution.
- Immediately upon notice if:
- a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
- a Covered Person materially misrepresents information provided to the Plan or Medical Mutual or commits fraud or forgery.

Continuation of Coverage During Military Service

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

- the date you return to reserve status from active military duty;
- the date coverage terminates under the Benefit Book for failure to make timely payment of a required contribution;
- the date the entire Benefit Book ends; or
- the date the coverage would otherwise terminate under the Benefit Book.

Benefits After Termination of Coverage

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

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

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

Rescission of Coverage

A rescission of coverage means that your coverage is retroactively terminated to a particular date, as if you never had coverage under the Plan after the date of termination. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf) performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. Your coverage may also be rescinded for any period of time for which you did not pay the required contribution to coverage.

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.

Extended Coverage

If a Card Holder ceases to be an active Religious of the Diocese and thereby ceases to be eligible for coverage, such Card Holder may be eligible to continue health coverage under this program for himself and his eligible Dependents for a period of eighteen months after the date of termination of his service with the Diocese if the following requirements are met:

- The Card Holder was covered under this program during the three (3) month period preceding the termination of his service;
- The Card Holder is not covered by or eligible for benefits under Medicare;
- The Card Holder is not covered by or eligible for coverage under any other group health plan; and
- The Card Holder was not terminated as a result of any gross misconduct.

In order to extend coverage in accordance with the provisions of this section, the Card Holder will be required to make the full monthly required contributions.

If a terminated Card Holder elects extended coverage, such coverage will cease upon the occurrence of any of the following events:

- becoming eligible for benefits under Medicare;
- becoming eligible and covered under any other group health plan;
- failure to make a timely payment of a required contribution; or
- the Diocese's failure to sponsor the program for its Religious.

Benefits for Retirees

Upon retirement, you may elect to continue coverage under the Program for yourself and covered dependents if you have been insured at least five years immediately preceding your retirement, and have attained age 55.

The coverage provided to retirees and their Eligible Dependents, if any, will be the same coverage which was provided to them when they were an active Religious. However, once retirees become eligible for Medicare, the Program will assume they are enrolled for both Medicare Part A and Medicare Part B, and any benefits payable under this Program will first be reduced by any such benefits they are eligible to receive from Medicare, as described under "Coordination of Benefits."

When a retiree dies, coverage can be continued for Eligible Dependents if they had coverage under the Program on the day before the retiree's death and they continue to make the necessary contributions as determined by the Diocese.

Authorized Leaves of Absence

If a Card Holder takes an authorized leave of absence, coverage under the program may be continued, at his own expense, for up to one (1) year following such leave.

HEARING SCHEDULE OF BENEFITS

Dependent Age Limit	Please refer to your medical Schedule of Benefits

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

TYPE OF SERVICE	**MAXIMUMS AND LIMITATIONS**
Hearing Aids (Not all hearing aids are covered or are covered in full, and you may be subject to balance billing.)	One hearing aid per ear, limited to $2,500 every rolling 36 months

COINSURANCE PAYMENTS	**Professional Charges**
TYPE OF SERVICE	**For Covered Services received from a Contracting Hearing Coverage Provider, you pay the following, based on the applicable Allowed Amount* or Non-Contracting Amount**
COINSURANCE	
Audiometric Examinations	0%
Conformity Evaluations	0%
Hearing Aids (Not all hearing aids are covered or are covered in full, and you may be subject to balance billing.)	0%
Hearing Aid Evaluation Tests	0%
Hearing Aid Repair	0%

***For Covered Services received from a Non-Contracting Provider, Medical Mutual's payment is based upon the Non-Contracting Amount, and you may be subject to balance billing and/or Excess Charges.**

Notes

The Coinsurance percentage will be the same for Non-Contracting Hearing Coverage Providers as Contracting Hearing Coverage Providers, but you may be subject to balance billing and/or Excess Charges.

HEARING SERVICES RIDER

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

HEARING SERVICES

The following are Covered Services:

- Audiometric Examinations. This examination must be performed by:
  - a Physician-Specialist; or
  - an Audiologist.
- Hearing aid evaluation tests. These tests must be performed by:
  - a Physician-Specialist; or
  - an Audiologist;

  and may include the trial and testing of various makes and models of hearing aids to determine which will best compensate for the loss of hearing. This evaluation testing must be indicated by the most recent Audiometric Examination.
- Hearing aids. (Not all types of hearing aids are covered or are covered in full, and you may be subject to balance billing.)
- Conformity evaluation. This follow-up visit must be to the:
  - prescribing Physician-Specialist; or
  - Audiologist;

  and is an evaluation of the performance of the prescribed hearing aid to determine the conformance of the hearing aid to the prescription.

Please Note: All benefits payable are subject to the Allowed Amount.

EXCLUSIONS

In addition to the non-covered items listed in the "Exclusions" section of this Benefit Book, no coverage is provided under this Rider for the following:

1. For medical examination of the ear by a Physician-Specialist to determine possible loss of hearing acuity.
2. For a hearing examination or materials ordered as a result of a hearing examination prior to your effective date.
3. For replacement of hearing aids that are lost or broken, unless at the time of such replacement, 36 months have elapsed since the Covered Person last received a hearing aid for which coverage was provided.
4. For ear molds and ear impressions.
5. For medical or surgical treatment.
6. Which are not prescribed by or performed by or upon the direction of a Hearing Coverage Provider.
7. For non-covered services or services specifically excluded in the text of this Rider.

DEFINITIONS

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

Audiologist - any person who:

- has a master's or doctorate's degree in audiology or speech pathology from an accredited university; and
- has a Certificate of Clinical Competence in Audiology or an Equivalency Certificate from the American Speech and Hearing Association; and
- is qualified in the state in which the service is provided to conduct an Audiometric Examination and hearing aid evaluation test for the purposes of measuring hearing acuity and determining and prescribing the type of hearing aid that would best improve the Covered Person's loss of hearing acuity.

Audiometric Examination - a procedure for measuring hearing acuity, including tests relating to air conduction, bone conduction, speech reception threshold and speech discrimination.

Hearing Coverage Provider - a Physician-Specialist, Audiologist, hearing aid specialist or dealer.

Physician-Specialist - an otologist or otolaryngologist who is board certified or eligible for certification in his specialty in compliance with standards established by his respective professional sanctioning body, who is a licensed doctor of medicine or osteopathy legally qualified to practice medicine.

Multi-Language Interpreter Services & Nondiscrimination Notice

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

Spanish

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

Chinese

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

German

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

Arabic

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

Pennsylvania Dutch

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

Russian

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

French

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

Vietnamese

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

Navajo

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

Oromo

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

Korean

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

Italian

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

Japanese

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

Dutch

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

Ukrainian

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

Romanian

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

Tagalog

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

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

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

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

Nondiscrimination Notice

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

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

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

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

Email: CivilRightsCoordinator@MedMutual.com

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

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

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