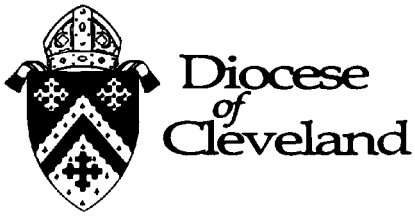

Lay Employees and Deacons

Group Number
228392-212, 217, 222

Skyway Plus Health Care Benefit Book

Hearing Rider

NOTICE:

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

MEDICAL MUTUAL SERVICES, LLC

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

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amendmamm
STSBPCM-OHS/NGF R7/18
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NSTSBPCM-ASO90380

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

SCHEDULE OF BENEFITS

To receive benefits under this Plan, Covered Services must be provided by Skyway Plus Providers, also referred to throughout this Benefit Book as "Network Providers."

THERE IS NO COVERAGE UNDER THIS PLAN FOR NON-NETWORK PROVIDERS, EXCEPT:

- In the event of an Emergency Medical Condition; and
- When a Covered Service is unavailable form a Network Provider, and you receive advance approval from Medical Mutual to obtain services from a Non-Network Provider.

Remember, in an emergency, always go to the nearest appropriate medical facility; your benefits will not be reduced if you go to a Non-Network or Non-Contracting Hospital in an emergency. However, you may be subject to balance billing if you utilize Non-Contracting Providers. Please see the "How Claims are Paid" section of this Benefit Book.

Network Providers: Skyway Plus Institutional and Professional Providers.

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

COMPREHENSIVE MAJOR MEDICAL BENEFIT	
Deductible per Benefit Period for Network Providers	
If you have single coverage:	$500
If you have family coverage:	$1,000
Coinsurance Limit per Benefit Period for Network Providers	
If you have single coverage:	$1,500
If you have family coverage:	$3,000
Out-of-Pocket Maximum per Benefit Period for Network Providers (Includes Deductibles, Copayments, and Coinsurance) (Prescription Drug is not administered by Medical Mutual)(1)	
If you have single coverage:	$2,000
If you have family coverage:	$4,000
Deductible and Out-of-Pocket Maximum Processing (2)	Embedded

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

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

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

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

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
Inpatient Hospital Days	365 days per confinement (3)
Outpatient Occupational and Physical Therapy Services	40 visits (combined)
Outpatient Speech Therapy Services	20 visits
Preventive Body Composition, Bacterial Stool Culture, Chest X-ray, Cholesterol Test (21 and over), Complete Blood Count (CBC), Comprehensive Metabolic Panel, Electrocardiogram (EKG), Hemocult, Prostate Specific Antigen (PSA) Test, Spirometry, Stress Test, Tonometry, Urinalysis (UA)	One each
Preventive Mammogram Services	One mammogram; mammograms are limited to 130% of the Medicare reimbursement amount; the maximum reimbursement amount applies only to Covered Services received inside the state of Ohio, as mandated by the state of Ohio.
Preventive Pap Test and Associated Examination	One test; One examination (age 21 and over)
Preventive Physical Examination (age 21 and over)	Males: One examination Females: Two examinations
Skilled Nursing Facility Services	120 days
Wigs	One wig

COINSURANCE AND COPAYMENTS FOR INSTITUTIONAL AND PROFESSIONAL CHARGES	
TYPE OF SERVICES	**For Covered Services received from a 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 for an Emergency Medical Condition	$150 Copayment, waived if admitted, not subject to the Deductible
Emergency Room Physician's Charges for an Emergency Medical Condition	0%, not subject to the Deductible
All other related Charges for an Emergency Medical Condition	0%, not subject to the Deductible
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	
Maternity	10%
Physical Medicine and Rehabilitation	10%
Semi-Private Room and Board	10%
Skilled Nursing Facility	10%
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	10%
Chiropractic Services	10%
Occupational and Physical Therapy Services	10%
Pulmonary Therapy Services	10%
Respiratory Therapy Services	10%
Speech Therapy Services	10%

COINSURANCE AND COPAYMENTS FOR INSTITUTIONAL AND PROFESSIONAL CHARGES	
TYPE OF SERVICES	**For Covered Services received from a 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.	
PHYSICIAN/OFFICE SERVICES (includes Mental Health and Substance Abuse Disorders)	
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
Office Visits using on-demand, virtual Telemedicine Services	$20 Copayment, not subject to the Deductible
Urgent Care Office Visits	$25 Copayment, not subject to the Deductible
PREVENTIVE AND WELLNESS SERVICES	
Preventive Services are provided in accordance with state and federal law. Please refer to the "Preventive and Wellness Services" health care benefit for details. (6)	0%, not subject to the Deductible
Endoscopic Procedures: Anoscopy, Proctoscopy, Proctosigmoidoscopy and Sigmoidoscopy only	0%, not subject to the Deductible
Endoscopic Procedures: Preventive Colonoscopy (Ages 45 and over) (7)	0%, not subject to the Deductible
Gynecological Examinations in Conjunction with a Pap Test (Age 21 and over)	0%, not subject to the Deductible
Preventive Testing Services: • Bacterial Stool Culture • Body Composition • Bone Density Test • Chest X-ray • Cholesterol Screening (Age 21 and over) • Complete Blood Count (CBC) • Comprehensive Metabolic Panel • Electrocardiogram (EKG) • Hemocult • Immunoassay for Tumor Antigen (CA125) • Prostate Specific Antigen (PSA) Tests • Spirometry • Stress Test • Tonometry • Urinalysis (UA)	0%, not subject to the Deductible
SURGICAL SERVICES	
Inpatient Surgery	10%
Medically Necessary Endoscopic Procedures (i.e, Colonoscopy, Sigmoidoscopy, etc.)	10%
Outpatient Surgery	10%
OTHER SERVICES	
Chest Wall Clapping	10%

COINSURANCE AND COPAYMENTS FOR INSTITUTIONAL AND PROFESSIONAL CHARGES	
TYPE OF SERVICES	**For Covered Services received from a 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.	
Hospice Services	0%, not subject to the Deductible
Lamaze and Birthing Classes	10%
Night Guards	10%
Outpatient Diabetic Education and Training	0%, not subject to the Deductible
All Other Covered Services	10%

Comprehensive Major Medical Notes

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-Pocket Maximum will not exceed the Network 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, preventive immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

SKYWAY PLUS 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 Plan Sponsor (the Group). 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 Plan and are referred to as **Covered Persons, you or your.** They must:

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

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

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 explains your Coinsurance, Copayment and Deductible obligations, if applicable.

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

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

The **Health Care Benefits** section explains your benefits and some of the limitations on the Covered Services available to you.

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

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

DEFINITIONS

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

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

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

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

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

Benefit 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 or Non-Contracting 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 - the status of a Provider:

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

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

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

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

Covered Person - the 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 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-Network or Non-Contracting 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.

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

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

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

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

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

Even if a drug, device, or portion of a medical treatment or procedure is determined to be Experimental or Investigational, 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.

Hospital - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

1. Provides room and board and nursing care for its patients;
2. Has a staff with one or more Physicians available at all times;
3. Provides 24-hour nursing service;
4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
5. Is fully accredited by The Joint Commission.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Extended care

9. Intermediate care
10. Skilled nursing care
11. Residential treatment care for mental health
12. Residential treatment care for substance abuse

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.

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.

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 or Pharmacy 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, volume-based credits or refunds or discount guarantees.

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

Network Provider - a Provider that is included in a limited panel of Providers as designated by Medical Mutual. A Network Provider may also be referred to throughout this Benefit Book as a "Skyway Plus Provider."

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

Non-Contracting Amount - subject to applicable law, the maximum amount allowed by Medical Mutual for Covered Services provided to Medical Mutual Covered Persons by a Non-Contracting Provider based on various factors, including, but not limited to, market rates for that service, Negotiated Amounts for that service, and Medicare reimbursement for that service. The Non-Contracting Amount will likely be less than the Provider's Billed Charges. Medical Mutual also reserves the right to pay a Non-Contracting Amount for Prescription Drugs received from a non-Network Pharmacy that is based on the lesser of the Billed Charges or an amount similar to or less than what Medical Mutual would pay a Network Pharmacy.

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

Non-Network Provider - the status of a Provider that does not meet the definition of a 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 applicable state law 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 - the following persons or entities which are licensed as required:

- advanced nurse practitioner (A.N.P.);
- ambulance services;
- audiologist;

- certified dietician;
- certified nurse-midwife;
- certified nurse practitioner;
- clinical nurse specialist;
- dentist;
- doctor of chiropractic medicine;
- durable medical equipment or prosthetic appliance vendor;
- laboratory (must be Medicare Approved);
- licensed independent social workers (L.I.S.W.);
- licensed practical nurse (L.P.N.);
- licensed Professional clinical counselor;
- licensed Professional counselor;
- licensed vocational nurse (L.V.N.);
- mechanotherapist (licensed or certified prior to November 3, 1975);
- occupational therapist;
- ophthalmologist;
- 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, other than those applicable to Prescription Drug benefits, 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 which 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. Payment of benefits is still subject to all other terms and conditions of the Plan.

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.

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.

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 - Prescription Drugs that:

- Are approved only to treat limited patient populations, indications or Conditions; and
- Are normally, but not always, injected, infused or require close monitoring by a Physician or clinically trained individual and meet one of the following:
  - the FDA has restricted distribution of the drug to certain facilities or Providers; or
  - require 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.

Telehealth Services - means health care services provided through the use of information and communication technology by a health care Professional, within the Professional's scope of practice, who is located at a site other than the site where either of the following is located:

a. The patient receiving the services;
b. Another health care Professional with whom the Provider of the services is consulting regarding the patient.

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

- has consistent, fair and practical criteria for selecting patients for transplants;

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

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

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

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

ELIGIBILITY

Enrolling for Coverage

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

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

Eligible Full-time Employees and Permanent Deacons

Persons eligible to participate in the program are lay employees and permanent deacons of a participating institution whose compensation is subject to withholding under Section 3402 of the Internal Revenue Code if they meet the requirements of either (a) or (b), as well as all the requirements of (c) through (f):

(a) such person is regulary scheduled to work full-time on an employment year basis for participating institutions (in the aggregate), and if hired as a temporary employee such employee has been employed for a 90-day period; or

(b) such person is regularly scheduled to work full-time on an academic year basis with respect to employment at an educational institution, and if hired as a substitute or temporary employee, such employee has been employed for a 90-day period; and

(c) such person has not entered into an oral or written agreement which prevents his or her participation in the program; and

(d) such person has not been hired as a contract or leased employee; and

(e) such person has not been hired as a seasonal employee for a period of six (6) months or less; and

(f) such person makes the required contributions, if any, for such coverage.

Full-time Employee

Generally, an individual who is employed by a Participating Institution which is an "Applicable Large Employer" would be considered full-time if the employee is regularly scheduled to work 30 hours or more per week. Hours include non-working hours for which the employee is paid such as lunch hours, vacation and sick days, and if the employee is a teacher, hours include both classroom and non-classroom hours worked as reasonably determined by the employer. An employee of an Applicable Large Employer who does not have regularly scheduled hours is considered to be a variable hour employee and would need to average 30 hours per week over a specified 12-month period in order to meet the full-time employee requirement.

A Participating Institution is an Applicable Large Employer if it:

(a) is part of the Catholic Diocese of Cleveland (such as a parish or Diocesan owned school); or

(b) employs a minimum of 50 "full-time equivalent" employees (employees of employers which are part of a controlled group are aggregated together to determine whether there are 50 "full-time equivalent" employees).

If a Participating Institution is not Applicable Large Employer, then such Participating Institution may require 35 hours of service per week (or if a teacher, 20 classroom hours) for an employee to be considered a full-time employee.

Eligible Part-time Employees and Permanent Deacons

Part-time lay employees and permanent deacons of a participating institution may participate in the program if:

(a) their employer adopts the program on behalf of its part-time employees and deacons; and

(b) the part-time lay employee or deacon is regularly scheduled to work at least 20 hours per week during an employment year (20 hours per week during an academic year if such person is employed at an educational institution); and

(c) the part-time lay employee or deacon has not entered into an oral or written agreement which prevents his participation in the program; and

(d) the part-time lay employee or deacon is not a contract or leased employee; and

(e) the part-time employee is not a temporary, seasonal or substitute employee; and

(f) the part-time employee or deacon makes the required contributions, if any, for coverage.

Participating Institutions

The following agencies and organizations may be "Participating Institutions" under the program:

- the administrative offices of the Diocese;
- any Diocesan corporation;
- any parish or parish school;
- all Catholic parish schools and Diocesan owned schools within the Diocese of Cleveland;
- any social or welfare agency operated by the Diocese or by a Diocesan corporation;
- any school, institution, social or welfare agency which is owned by the Diocese or a Diocesan corporation; and
- any school or institution in the geographical area of the Diocese of Cleveland which is affiliated with the Roman Catholic Church but which is not owned by either the Diocese or a Diocesan corporation.

Eligible Dependents

An Eligible Dependent is:

- the Card Holder's lawful spouse, as defined in your Group's plan documents and/or summary plan description, provided you are not legally separated. You may be required to provide a copy of a marriage certificate. This plan will not cover the same-sex spouse of an Employee, regardless of where the marriage took place.
- the Card Holder's or eligible spouse's:
  - biological children; or
  - children placed for adoption and legally adopted children.

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

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

Child Support Order

In general, a medical child support order is a court order that requires an Eligible Employee to provide medical coverage for his or her children in situations involving divorce, legal separation or paternity dispute. A medical child support order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. This Plan provides benefits according to the requirements of a medical child support order that is entered by a court of competent jurisdiction or by a local child support enforcement agency. The Group will promptly notify affected Card Holders if a medical child support order is received. The Group will notify these individuals of its procedures for determining whether medical child support orders meet the requirements of the Plan; within a reasonable time after receipt of such order, the Group will determine whether the order is acceptable and notify each affected Card Holder and of its determination. Once the dependent child is enrolled under a medical child support order, the child's appointed guardian will receive a copy of all pertinent information provided to the Eligible Employee. In addition, should the Eligible Employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

Effective Date

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

Changes in Coverage

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. A change in status occurs with your marriage or divorce, the death of your spouse or a dependent, the birth or adoption of your child, your dependent commencing or ceasing to satisfy the eligibility requirements for dependent coverage, the termination of employment or the commencement of employment of your spouse, the switching from part-time to full-time or from full-time to part-time status by you or your spouse, the taking of an unpaid leave of absence by you or your spouse, a change in residence or a change in worksite for you or your spouse. All changes in status must be reported to the Administrator within 31 days of the event so as not to adversely affect your ability to revoke your election and make a new election.

If a premium change (as described above) is required and Medical Mutual is not notified of the change within 31 days of the event, the Effective Date of your coverage will be determined in accordance with the Group Contract. It is important to complete and submit your Enrollment Form promptly as the date this new coverage begins will depend on when you request enrollment.

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

   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 <u>*only if*</u>:

   - 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. <u>Marketplace Exchange Open Enrollment</u>

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. Termination of an employee's or dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)
    j. The employee or dependent is determined to be eligible for premium assistance in the Group's plan under a Medicaid or CHIP plan
3. If you or your Eligible Dependent has COBRA coverage, the coverage must be exhausted in order to trigger a special enrollment right. Generally, this means the entire 18, 29 or 36-month COBRA period must be completed in order to trigger a special enrollment for loss of other coverage.
4. Enrollment must be supported by written documentation of the termination of the other coverage with the effective date of said termination stated therein. With the exception of items "i" (termination of Medicaid or CHIP coverage) and "j" (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 "i" and "j" 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 lay employee or permanent deacon no longer meets the requirements for eligibility, regardless of whether such terminated employee 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.
- Dependents' coverage ceases on the last day of the month in which the lay employee or permanent deacon is no longer eligible for coverage or ceases making the required contributions or if the Eligible Dependent ceases to meet the Plan's definition of Eligible Dependent.
- Termination of the Group Contract 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 any Covered Person's Group coverage would otherwise end, you and your Eligible Dependents 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 section describes the services and supplies covered if provided and billed by Providers. All Covered Services must be Medically Necessary unless otherwise specified.

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

Women's Health and Cancer Rights Act Notice

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

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 or Residential Treatment Facility require Preauthorization. The telephone number for Preauthorization is listed on the back of your identification card. Network Providers and Contracting Providers are responsible for obtaining Preauthorization for you.

Allergy Tests and Treatments

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

Ambulance Services

To be covered, ambulance services must be **Medically Necessary**. We will provide benefits for ambulance transportation by a licensed, professional ground ambulance service to the closest facility that can provide the needed services appropriate for your Condition.

Covered transportation:

- from the scene of an accident or Emergency Medical Condition to the closest Hospital to provide Emergency Services;
- from one Hospital to another Hospital, including when we require a Covered Person to move from a Non-Network Hospital to a Network Hospital;
- from a Hospital or a Skilled Nursing Facility to your home or to another facility, if an ambulance is the only safe way to transport you;

- from your home to a Hospital, if an ambulance is the only safe way to transport you;
- When during a covered Inpatient stay at a Hospital, Skilled Nursing Facility or acute rehabilitation Hospital, an ambulance is required to safely and adequately transport you to or from Inpatient or Outpatient Medically Necessary treatment.

It's important to note:

- Ambulance services are a Covered Service only when the Covered Person's Condition is such that use of any other method of transportation could endanger the Covered Person's health.
- Covered Services include treatment of a sickness or injury by medical Professionals from an ambulance service when you are not transported, if Medically Necessary.
- 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 for Conditions other than Emergency Medical Conditions via ambulance are a Covered Service only when Medically Necessary and certified by a Physician, except:
  - when a Covered Person is required by Medical Mutual to move from a Non-Network Provider to a Network Provider; or
  - when ordered by an employer, school, fire or public safety official, and the Covered Person is not in a position to refuse.

Non-Covered services for ambulance include, but are not limited to, trips to a Physician's office clinic, a morgue or a funeral home.

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.

Biofeedback Services

Biofeedback Training is a presentation of immediate visual or auditory information about usually unconscious body functions. Either by trial and error or by operant conditioning, a Covered Person can learn to repeat behavior which results in a satisfactory level of body functions.

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 in the Network 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.

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

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

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

Diagnostic Services

A diagnostic service is a test or procedure performed, when you have specific symptoms, to detect or monitor your Condition. It must be ordered by a Physician or Other Professional Provider. Covered diagnostic services are 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 Medically Necessary Emergency Services for an Emergency Medical Condition. Emergency Services are available 24 hours a day, 7 days a week.

In the event of an emergency:

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

Emergency Services do not require Prior Authorization and are payable at the Network level of benefits shown in the Schedule of Benefits, regardless of whether these services are obtained from a Network Provider, a Non-Network Provider or a Non-Contracting Provider.

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 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 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.

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;
- 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 Health Education Services

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

Inpatient Hospital Services

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

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

- a semiprivate room or ward;
- a private room, when Medically Necessary; if you request a private room, 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 or Alcoholism).**

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

Inpatient admissions to a Hospital require Preauthorization. The telephone number for Preauthorization is listed on the back of your identification card. Network Providers and Contracting Providers are responsible for obtaining Preauthorization for you.

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

- parent education;

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

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

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

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

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

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

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

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 enrolling for family coverage.

Office Visits

- Office visits and consultations to examine, diagnose and treat a Condition are Covered Services. You may be charged for missed office visits if you fail to give notice or reasonable cause for cancellation.
- Telehealth Services are covered as appropriate for the services being rendered by the Covered Person's Provider. For example, audio-only Telehealth Services are generally Covered Services, unless it is not clinically appropriate to provide such services without a face-to-face interaction.

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;
- 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.

Be sure to contact Medical Mutual before selecting your DME so that you understand the rental and/or purchase options that are available under this Plan.

Covered DME includes:

- blood glucose monitors;
- respirators;
- home dialysis equipment;
- wheelchairs;
- hospital beds;
- crutches;
- mastectomy bras; and
- augmentive communication devices, when approved by Medical Mutual, based on the Covered Person's Condition.

Deluxe

If the supplies, equipment and appliances include comfort, luxury or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your Condition, reimbursement will be based on the maximum allowable charge for a standard item that is a Covered Service, serves the same purpose and is Medically Necessary. Any expense that exceeds the maximum allowable charge for the standard item which is a Covered Service is your

responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your Condition.

Repair/Warranty/Misuse

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Medical Mutual. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

1. The equipment, supply or appliance is a Covered Service;
2. The continued use of the item is Medically Necessary;
3. There is reasonable justification for the repair, adjustment, or replacement. (Warranty expiration is not reasonable justification.)

In addition, replacement of purchased equipment, supplies or an appliance may be covered if:

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. A Covered Person's clinical needs have changed, and the current equipment is no longer usable. For example: due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired. Benefits for repairs and replacement do not include the following:
    - Repair and replacement due to misuse, malicious breakage or gross neglect.
    - Replacement of lost or stolen items.

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

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

Orthotic Devices - rigid or semi-rigid supportive devices used: 1) to support, align, prevent or correct deformities; 2) to improve the function of movable parts of the body; or 3) which limit or stop motion of a weak or diseased body part.

These devices include, but are not limited to:

- Cervical collars;
- Ankle foot orthosis;
- Corsets (back and surgical);
- Splints (extremity);
- Trusses and supports;
- Slings;
- Wristlets;
- Built-up shoes; and
- Custom-made shoe inserts.

Covered Services for orthotic devices are:

- The initial purchase, fitting and repair of the device.
- The cost of casting (if billed with the orthotic device and not separately), molding, fittings and adjustments.

- One replacement per year when Medically Necessary. Benefits may also be provided for Covered Persons under age 18, due to rapid growth, or for any Covered Person when an appliance is damaged and cannot be repaired.

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

- **Orthopedic shoes (except therapeutic shoes for diabetes);**
- **Non-custom-made foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;**
- **Standard elastic stockings, garter belts; and**
- **Corn and bunion pads.**

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

Inpatient admissions to a Hospital or Residential Treatment Facility require Preauthorization. The telephone number for Preauthorization is listed on the back of your identification card. Network Providers and Contracting Providers are responsible for obtaining Preauthorization for you.

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 proposed course of treatment and the Inpatient stay for the organ transplant both require Preauthorization from Medical Mutual. Network Providers and Contracting Providers are responsible for obtaining this Preauthorization for you.

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

- 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.

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 function 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.

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

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.

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.

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

Preventive and Wellness Services

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

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

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

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

  - Health Education Services
    - 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.
  - Gynecological Services
    - Mammogram services; and
    - PAP tests and associated examinations.
  - Physical Examinations
  - Screenings
    - blood glucose screenings and screening for type 2 diabetes
    - bone density screenings for women
    - chlamydia screenings, limited to pregnant and sexually active women
    - cholesterol screenings
    - colorectal cancer screenings: using fecal occult blood testing, sigmoidoscopy or colonoscopy
    - hepatitis B virus screenings; limited to pregnant women in their first prenatal visit.
  - Smoking cessation services
  - Well child care services
  - Women's preventive services
    - These services include, but are not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; breastfeeding; and domestic violence.

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

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

Diabetic self-management training and education 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.

Preventive Testing - the following tests are covered:

- Allergy Testing
- Bacterial Stool
- Body Composition
- Bone Density Screenings
- Cardiovascular Stress Test
- Chest X-ray
- Cholesterol Testing
- Complete Blood Count (CBC)
- Comprehensive Metabolic Panel
- Electrocardiogram (EKG)
- Electrolyte Panel
- Endoscopic procedures:
  - Anoscopy
  - Colonoscopy - beginning at age 45
  - Proctoscopy
  - Proctosigmoidoscopy
  - Sigmoidoscopy

Colonoscopies are Covered Services for Covered Persons ages 45 and over. Other endoscopic procedures (sigmoidoscopy, anoscopy and proctosigmoidoscopy) are Covered Services for Covered Persons of all ages. Endoscopic services for a medical Condition are payable as a Medically Necessary diagnostic procedure under the Surgical Services benefit. A Deductible, Copayment and/or Coinsurance may apply. Routine endoscopic procedures are payable under the preventive level of benefits.

- Hemoccult
- Immunoassay for Tumor Antigen (CA 125)
- Obstetric Panel
- Prostate Specific Antigen (PSA) Test
- Spirometry
- Tonometry
- Urinalysis (UA)

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, and your Physician must certify all services initially and continue to certify that you are receiving Skilled Care and not Custodial Care as requested by Medical Mutual. All Covered Services will be provided according to your Physician's treatment plan and as authorized by Medical Mutual.

No benefits are provided:

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

Surgical Services

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

- 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

Temporomandibular Joint Syndrome (TMJ) is a Condition which causes pain or dysfunction in the temporomandibular joint and/or the temporal region. This syndrome may include limited motion of the jaw caused by improper occlusal alignment. Occlusal refers to the fit of the teeth as the two jaws meet.

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.

EXCLUSIONS

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

1. Received from other than a Network Provider except for an Emergency Medical Condition or if otherwise specified in this Benefit Book.
2. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
3. Not performed within the scope of the Provider's license.
4. Not Medically Necessary or do not meet Medical Mutual's policy, clinical coverage guidelines, or benefit policy guidelines.
5. Received from other than a Provider.
6. For Experimental or Investigational drugs, devices, medical treatments or procedures, unless otherwise specified.
7. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
8. For a Condition that occurs as a result of any act of war, declared or undeclared.
9. For a Condition resulting from direct participation in a riot, civil disobedience, nuclear explosion or nuclear accident.
10. For which you have no legal obligation to pay in the absence of this or like coverage.
11. 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.
12. Received from a member of your Immediate Family.
13. Incurred after you stop being a Covered Person unless otherwise specified in the Benefits After Termination of Coverage section.
14. 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.
15. For radiologic imaging with no preserved film image or digital record.
16. 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.
17. For which benefits would have been payable under Part B of Medicare if a Covered Person had enrolled in Part B coverage. For the purposes of the calculation of benefits, if the Covered Person is eligible for, but has not enrolled in, Medicare Part B, Medical Mutual will calculate benefits as if he or she had enrolled. This provision only applies where Medicare is the primary payer under the law.
18. Received in a military facility for a military service related Condition.
19. For court-ordered testing or care unless Medically Necessary.
20. For Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss or weight loss Surgery), unless otherwise specified.
21. 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.
22. For Surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment.
23. For the removal of tattoos.
24. For dietary and/or nutritional counseling or training, unless otherwise specified or required by PPACA.
25. 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.

26. For treatment of learning disabilities, other than treatment necessary to evaluate or diagnose these Conditions.
27. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss or obesity.
28. For nutritional supplements taken orally.
29. For marital counseling.
30. For gender affirming Surgery, or any treatment leading to or in connection with gender affirming Surgery.
31. For Contraceptives and over-the-counter birth control devices.
32. For Contraceptive devices, which include, but are not limited to, IUD's, diaphragms and cervical caps.
33. For sterilizations, except to remove a pathological Condition that threatens the life or physical Condition of the patient and reversals of sterilization.
34. For devices, equipment and supplies used for the treatment of sexual dysfunction that is psychological or cosmetic in nature.
35. For abortions, unless the pregnancy would endanger the life of the mother.
36. For voluntary family planning services.
37. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.
38. For treatment associated with teeth, dental X-rays, dentistry or any other dental processes, including treatment with intraoral prosthetic devices or any other method to alter vertical dimension of occlusion, or orthognathic (jaw) Surgery. This exclusion does not apply to treatment of temporomandibular joint (TMJ) disorders.
39. 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.
40. For personal hygiene and convenience items.
41. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except as described in the section entitled "Prosthetic Appliances" under the "Medical Supplies and Durable Medical Equipment" benefit.
42. 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).
43. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
44. For lost, stolen, or damaged medical supplies or durable medical equipment.
45. For massotherapy or massage therapy, except as directly performed by a licensed physical therapist, occupational therapist or chiropractor.
46. For hypnosis and acupuncture.
47. For blood which is available without charge. For Outpatient blood storage services.
48. For the services of blood donors.
49. For Prescription Drugs, except as specified.
50. For preventive services, unless otherwise specified and in accordance with state and federal law.
51. For specialized camps.
52. For wilderness therapy, therapeutic living communities (including therapeutic farms), adventure-based therapy or similar programs.
53. For water aerobics.
54. For After Hours Care.
55. For missed appointments, completion of claim forms or copies of medical records.
56. For an interpretation charge by a pathologist when the interpretation or result is already automatically provided by a machine-read or automated laboratory test.
57. For stand-by charges of a Physician.
58. For any Charges not documented in Provider records.
59. For fraudulent or misrepresented claims.
60. For charges for doing research with Providers not directly responsible for your care.
61. For services as the result of an injury or illness caused by or contributed to by engaging in an assault or felony.

62. For a particular health service in the event that a Provider waives Copayments, Coinsurance (and/or the Deductible per Benefit Period); in such event, no benefits are provided for the health service for which the Copayments, Coinsurance (and/or the Deductible per Benefit Period) are waived.
63. For those very limited situations in which services from a Non-Contracting Provider may be covered, the following exclusion applies:

    For services billed by a Non-Contracting Provider that would not be covered if billed by a Contracting Provider, due to medical policy or other care management provisions, and for which the Contracting Provider would hold the patient harmless. If a Non-Contracting Provider bills the Covered Person for such services, the Covered Person is responsible for the cost of those services and must pay that Provider.
64. For non-Covered Services or services specifically excluded in the text of this Benefit Book.

GENERAL PROVISIONS

How to Apply for Benefits

Notice of Claim; Claim Forms

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

If you fail to receive 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

Medical Mutual, as the claims administrator, pays for benefits on behalf of the Plan for Covered Services through agreements with Network Providers and Contracting Providers based on the Allowed Amount. Since Medical Mutual has agreements with these Providers, they have agreed not to bill for any amount of Covered Charges above the Allowed Amount, except for services and supplies for which Medical Mutual has no financial responsibility due to a benefit maximum.

This Plan provides coverage for services received from Network Providers only, except for an Emergency Medical Condition, or if otherwise specified in this Benefit Book. For any Covered Services obtained from a Non-Contracting Provider, Medical Mutual calculates its payments based on the Non-Contracting Amount, unless otherwise required by applicable law. Any charges exceeding the Non-Contracting Amount will not apply toward any Deductible, Out-of-Pocket Maximum or benefit maximum accumulation.

Refer to the Schedule of Benefits to determine the amount of Copayments, Deductibles and Coinsurance that may apply when utilizing a Provider.

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 a Network Provider but are unexpectedly treated by a Non-Network or Non-Contracting Provider.

You have protection against surprise billing and balance billing for the services described below ONLY. Non-Network Providers and Non-Contracting 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 Network level of benefits and will accumulate toward your Network Out-of-Pocket Maximum.

- Emergency Services
- Ambulance Services received from a Non-Network Provider or Non-Contracting Provider (Refer to the Health Care Benefit entitled "Ambulance Services" for additional information.)
- Unanticipated Covered Services received from a Non-Network Provider or Non-Contracting Provider at a Network or Contracting 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-Network Provider or Non-Contracting Provider, but only if there is no Network Provider or Contracting Provider who can furnish the item or service at that facility; and 6) any additional services required by applicable law or subsequent guidance issued thereto.

Remember that, outside of the services described above, this Plan does not cover services received from Non-Network Providers and Non-Contracting Providers. Should you elect to knowingly and purposefully seek care from a Non-Network Provider or Non-Contracting 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 Provider.

Before you can consent to be balance billed, your Non-Network Provider or Non-Contracting 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.

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.

Your Financial Responsibilities

You are responsible for:

- Any Copayment, Deductible and Coinsurance amounts specified in the Schedule of Benefits. Copayments are generally required to be paid at the time of service. Some Providers can determine the amount due for your Deductible and Coinsurance from Medical Mutual and may require payment from you before providing their services.
- Non-Covered Charges.
- Billed Charges for all services and supplies after benefit maximums have been reached.
- Any charges, other than for services described in the “No Surprise Billing” section of this Certificate, received from Non-Network Providers or Non-Contracting Providers.
- Billed Charges for services that are not Medically Necessary.
- Incidental charges.

For Covered Services, Medical Mutual will calculate its payment based upon either the Allowed Amount or Non-Contracting Amount.

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 benefit maximums.

Benefit Period Deductible

Each Benefit Period, you must pay the dollar amount(s) shown in the Schedule of Benefits as the Deductibles, 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, the Plan records must show that you have Incurred claims totaling the specified dollar amount, so submit copies of all your bills for Covered Services. Your Deductible accumulations do not necessarily occur in the same order that you receive services, but in the order in which Medical Mutual receives and processes your claims.

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

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

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

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

Coinsurance

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

Copayments

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

Out-of-Pocket Maximum

This is the amount of Copayments, Deductibles and Coinsurance for which Covered Persons are responsible each Benefit Period for Covered Services. After the applicable Out-of-Pocket Maximum shown in the Schedule of Benefits has been met, no additional Copayments, Deductibles or Coinsurance are required from Covered Persons for Covered Services

for the remainder of the Benefit Period, unless otherwise specified in this 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 Coinsurance Limit(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 and Contracting Providers for Covered Services.

Some of Medical Mutual's contracts with Providers, including Institutional Providers, allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual and/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.

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

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

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

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

If a benefit payment is made by Medical Mutual, to you or to your Provider on your behalf, that exceeds the benefit amount you are entitled to receive, Medical Mutual has the right to require the return of the overpayment from you or your Provider within two years of the payment. If Medical Mutual seeks payment from your Provider, Medical Mutual will first send an invoice to the Provider that explains why it is seeking a refund. The Provider can then send the refund or appeal the determination. If your Provider does not do one of those things, Medical Mutual reserves the right to reduce or offset any future benefit payment due to that Provider, on behalf of a Covered Person, by the amount of the overpayment. The amount of the overpayment can also be recovered by reducing or offsetting future payments to the Provider for this plan and/or other plans insured or administered by Medical Mutual. This right does not affect any other right of recovery Medical Mutual may have with respect to overpayments.

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

Prior Approval of Non-Network Benefits

There may be certain services that you know in advance can only be obtained from a Non-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-Network Provider, you must obtain approval in advance from Medical Mutual for services that cannot be provided by a 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 a Network Provider.

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

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

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

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

Preauthorization

All non-emergency Inpatient stays and certain Outpatient tests, procedures and equipment require Preauthorization.

Examples of Outpatient services that may require Preauthorization are:

- Durable medical equipment and devices
- MRIs and PET scans
- Therapy
- Home health care
- Private duty nursing

For a complete and current listing, please visit the "Benefits and Coverage" section of My Health Plan and click "Prior Approval" or contact customer Service at the phone number shown on your identification card. Be sure to check this listing before services are received, as the information is subject to change.

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

Contracting and Network Providers will assure that Preauthorization is obtained for you.

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

Please refer to the General Provision entitled, "Benefit Determination for Claims" for additional Preauthorization requirements.

Explanation of Benefits

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

Time of Payment of Claims

Benefits will be provided under this Benefit Book within 30 days after receipt of a completed claim. If supporting documentation is required, then payment will be made in accordance with 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, Medical Mutual will provide coverage at the Network Provider level.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of Medical Mutual, Medical Mutual will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of Medical Mutual, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of Medical Mutual, disability affecting a significant number of a 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 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 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.

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 law, if any provisions of this section are extended beyond the emergency period.

1. 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.
2. 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.
3. Limited extensions are provided for certain notification requirements relative to special enrollment, COBRA elections and filing of claims and appeals.
4. To the extent federal law requires different benefits and/or coverage than described above, the Plan will be deemed to include those benefits and/or coverage.

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, and your complaint is regarding an Adverse Benefit Determination, you may continue to pursue the matter through the appeal process.

Benefit Determination for Claims (Internal Claims Procedure)

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 health and medicine; however, any Physician with knowledge of the claimant's medical Condition can also determine that a claim involves Urgent Care.

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

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

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

Concurrent Care Claims

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

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

Pre-Service Claims

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

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

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

Post-Service Claims

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

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

If an extension is needed because you did not provide all of 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.

Right of Recovery

If the amount of the payments made by Medical Mutual is more than it should have paid under this plan, 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.

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, as described in this Benefit Book, stops:

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

Continuation of Coverage During Military Service

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

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

Benefits After Termination of Coverage

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

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

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

Rescission of Coverage

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

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 Covered Person's employment has terminated, and he/she thereby ceases to be eligible for coverage, such employee may be eligible to continue health coverage under this program for a period of 18 months after the date of termination of employment if the following requirements are met:

- The Covered Person was covered under this program during the entire three (3) month period preceding the termination of employment;
- The Covered Person is not covered by nor eligible for benefits under Medicare;
- The Covered Person is not covered by nor eligible for coverage under any other group health plan, as an employee or otherwise.

In order to extend coverage in accordance with the provisions of this Section, the Covered Person will be required to make the full monthly required contributions.

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

- becoming eligible for benefits under Medicare;
- become eligible and covered under any other group health plan, as an employee or otherwise;
- failing to make a timely payment of a required contribution;
- the Diocese ceases to sponsor any group health plan for its lay employees.

However, a dependent of a deceased or retired lay employee may continue coverage under the program indefinitely provided that such dependent:

- was an eligible dependent under the provisions of the program on the date of death or retirement of such lay employee; and
- pays the full cost of such coverage as determined from time to time by the Diocese.

The term extended coverage for such dependents will be in the discretion of the Diocese but may not exceed the earliest to occur of the following:

- the marriage or remarriage of such dependents;
- the dependents' attainment of the age limit;
- coverage of such dependents under another group medical program; and
- the termination of this program.

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 Member. 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.

BENEFIT MAXIMUMS PER COVERED PERSON	
Hearing Aids	One hearing aid per ear, limited to $2,500 every rolling 36 months

COINSURANCE PAYMENTS	**Professional Charges**	**Professional Charges**
TYPE OF SERVICE	**For Covered Services received from a Contracting Provider you pay the following portion, based on the Allowed Amount**	**For Covered Services received from a Non-Contracting Provider, you pay the following portion, based on the Non-Contracting Amount**
HEARING SERVICES		
Audiometric Examinations	0%	
Hearing Aid Evaluation Tests	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 Batteries	10% after the Deductible displayed in the "Comprehensive Major Medical Benefit" is satisfied. This Deductible is specified in the Schedule of Benefits located in the beginning of this Benefit Book.	Not Covered
Hearing Aid Repair	0%	
Conformity Evaluations	0%	

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.)
- Hearing aid batteries.
- 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.