MAYFIELD CITY SCHOOLS

Group Number
678059-001, 101

PPO Network Comprehensive Major Medical Health Care Certificate

Prescription Drug Rider

Vision Rider

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PPO NETWORK COMPREHENSIVE MAJOR MEDICAL SCHEDULE OF BENEFITS

Benefit Period	Calendar year
PPO Network Deductible per Benefit Period	$100 single / $200 family
Non-PPO Network Deductible per Benefit Period	$100 single / $200 family
Dependent Age Limit	The 19th birthday or the 24th birthday if the dependent is a Full-time Student
Non-PPO Network Coinsurance Limit	$500 single / $1,000 family

Any amounts applied to your PPO Network Deductible will also be applied to your Non-PPO Network Deductible. Any amounts applied to your Non-PPO Network Deductible will also be applied to your PPO Network Deductible.

Any Excess Charges you pay for claims will not accumulate towards the Non-PPO Network Coinsurance Limits.

Covered Services that require a Copayment are not subject to the Benefit Period Deductible Provisions.

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

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

To receive maximum benefits you must use PPO Network Providers. PPO Network Providers may change. Medical Mutual will tell you 60 days before a PPO Network Hospital becomes Non-PPO Network.

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

Preexisting Condition Exclusion Period

This provision will not apply to Certificate Holders and Eligible Dependents who are covered on the Group's initial Effective Date.

Preexisting Condition exclusions will be determined by the certificate in effect under this Contract on your Enrollment Date.

A Preexisting Condition is a Condition, other than pregnancy, for which you Incurred medical expenses, received medical treatment, used Prescription Drugs or were advised by a Physician or Other Professional Provider to receive treatment prior to your Enrollment Date. Your Enrollment Date is your Effective Date or, if earlier, the first day of your waiting period for enrollment.

If a Preexisting Condition existed at any time during the six-month period immediately preceding your Enrollment Date, Medical Mutual will provide benefits for the Preexisting Condition for Covered Services Incurred after nine months following your Enrollment Date.

If you had other health care coverage prior to your Enrollment Date, and you did not experience a Significant Break in Coverage, your prior coverage will be credited toward the nine-month exclusion period. A Significant Break in Coverage is a period of 63 consecutive days during which you did not have any other health care coverage, except that waiting periods are carved out. The standard method, which does not consider specific benefits, is used to determine creditable coverage.

BENEFIT PERIOD MAXIMUMS PER COVERED PERSON	
Child Health Supervision Services and Well Child Care	Unlimited
Chiropractic Visits	24 visits
Durable Medical Equipment (DME)	$50,000
Home Health Care Services	60 visits
Inpatient Drug Abuse and Alcoholism Services	30 days (1)
Inpatient Mental Health Care (that is not Biologically Based Mental Illness)	30 days
Inpatient Physical Rehabilitation	60 days
Invitro Fertilization/Artificial Insemination	$10,000
Outpatient Drug Abuse and Alcoholism Services	27 visits (1)
Outpatient Mental Health Care (that is not Biologically Based Mental Illness)	27 visits
Outpatient Institutional Cardiac Rehabilitation Services	50 visits
Outpatient Professional Cardiac Rehabilitation Services	50 visits
Outpatient Occupational Therapy Services	50 visits
Outpatient Physical Therapy Services	50 visits
Outpatient Institutional Pulmonary Therapy Services	50 visits
Outpatient Professional Pulmonary Therapy Services	50 visits
Outpatient Speech Therapy Services	50 visits
Routine Mammogram Services	One mammogram; limited to 130% of the Medicare reimbursement amount; the maximum reimbursement amount applies only to Covered Services received inside the state of Ohio, as mandated by the state of Ohio.
Routine PAP Tests	One test
Skilled Nursing Facility Services	60 days

MAXIMUM BENEFIT PAYABLE PER TRANSPLANT PER COVERED PERSON	
For the transplant of a human donor organ when received from a Non-PPO Network Provider	$30,000

MAXIMUM BENEFIT PAYABLE PER LIFETIME PER COVERED PERSON	
For Hospice Services	360 days
For all Other Covered Services, including any Prescription Drug benefits	Unlimited

COINSURANCE PAYMENTS	Institutional and Professional Charges	Institutional and Professional Charges
TYPE OF SERVICE	**For Covered Services received from a PPO Network Provider you pay the following**	**For Covered Services received from a Non-PPO Network or Non-Contracting Provider you pay the following**
EMERGENCY SERVICES		
Emergency - Emergency Room - the Institutional charge for use of the Emergency Room	$125 Copayment, waived if admitted, then 0% of Lesser Amount	$125 Copayment, waived if admitted, then 0% of Lesser Amount or Covered Charges
Emergency Services - all other related Institutional and Professional charges	0% of Lesser Amount	0% of Lesser Amount or Covered Charges
Non-Emergency - Emergency Room - the Institutional charge for use of the Emergency Room	$125 Copayment, waived if admitted, then 0% of Lesser Amount	$125 Copayment, waived if admitted, then 20% of Lesser Amount or Covered Charges
Non-Emergency Services - all other related Institutional and Professional charges	0% of Lesser Amount	20% of Lesser Amount or Covered Charges
BIOLOGICALLY BASED MENTAL ILLNESS SERVICES		
Biologically Based Mental Illness Services	Any applicable Deductible, Coinsurance or Copayment corresponds to the type of service received and is payable on the same basis as any other illness (e.g., emergency room visits for a Biologically Based Mental Illness will be paid according to the Emergency Services section above).	
CHILD HEALTH SUPERVISION, MEDICALLY NECESSARY AND ROUTINE SERVICES		
All Immunizations, Allergy Testing and Treatment, Outpatient Diagnostic and Routine Laboratory, Mammogram, Medical Testing, Pap Test, and X-Ray Services	0% of Lesser Amount, Deductible is waived	20% of Lesser Amount or Covered Charges
Child Health Supervision Examinations, Routine Endoscopic Services, Routine Physical, Hearing, and Vision Examinations	0% of Lesser Amount, Deductible is waived	20% of Lesser Amount or Covered Charges
Medically Necessary Office Visits	$15 Copayment per day, then 0% of Lesser Amount	20% of Lesser Amount or Covered Charges
Therapeutic Injections received in a physician's office	0% of Lesser Amount, Deductible is waived	20% of Lesser Amount or Covered Charges
Urgent Care Provider Office Visits	$20 Copayment, then 0% of Lesser Amount	$20 Copayment, then 0% of Lesser Amount or Covered Charges
MENTAL HEALTH CARE, DRUG ABUSE AND ALCOHOLISM SERVICES		
Inpatient and Outpatient Mental Health Care Services	0% of Lesser Amount	20% of Lesser Amount or Covered Charges
Outpatient Mental Health Care, Drug Abuse and Alcoholism Services	Group Therapy, $5 Copayment, Individual Therapy, $15 Copayment, then 0% of Lesser Amount, All other services, 0% of Lesser amount, Deductible is waived	20% of Lesser Amount or Covered Charges
OUTPATIENT THERAPY SERVICES		
Cardiac Rehabilitation, Chiropractic Visits, Occupational, Physical, Pulmonary, and Speech Therapy	$15 Copayment per day, 0% of Lesser Amount	20% of Lesser Amount or Covered Charges
SURGICAL SERVICES		
Outpatient Anesthesia and Assistant Surgeon Services received in a Physician's Office	0% of Lesser Amount, Deductible is waived	20% of Lesser Amount or Covered Charges
Outpatient Surgical Services received in a Physician's Office	$15 Copayment per day, then 0% of Lesser Amount	20% of Lesser Amount or Covered Charges
OTHER SERVICES		
Accidental Dental and Ambulance Services	0% of Lesser Amount	0% of Lesser Amount or Covered Charges
All Other Covered Services	0% of Lesser Amount	20% of Lesser Amount or Covered Charges

Notes

The Coinsurance percentage will be the same for Non-Contracting Providers as Non-PPO Network Providers but you may be subject to balance billing and/or Excess Charges. Payments to Contracting Non-PPO Network Providers are based on Negotiated Amount. Payments to Non-Contracting Providers are based on the Non-Contracting Amount.

1. If the Benefit Period maximum has been reached by a Covered Person and that Covered Person has received less than $550 in benefits for Alcoholism services, additional benefits are payable until $550 in benefits have been paid for Alcoholism services.

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL HEALTH CARE CERTIFICATE

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

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

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

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

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

NOTICE:

If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and Hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.

Medical Mutual of Ohio (Medical Mutual)

DEFINITIONS

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

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

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

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 Non-PPO Network Coinsurance Limits are accumulated. The first and/or last Benefit Periods may be less than 12 months depending on the Effective Date and the date your coverage terminates.

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

Biologically Based Mental Illness - schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

Birth Year - a 12 month rolling year beginning on the individual's birthdate.

Certificate - this document.

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

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

Coinsurance - a percentage of the Lesser Amount for Contracting Institutional Providers and Physicians and Other Professional Providers or a percentage of the Non-Contracting Amount for Non-Contracting Institutional Providers for which you are responsible after you have met your Deductible or paid your Copayment.

Coinsurance Limit - a specified dollar amount of Coinsurance expense Incurred in a Benefit Period by a Covered Person for Covered Services received from a PPO Network Provider.

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

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

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

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

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

Copayment - a dollar amount, if specified in the Schedule of Benefits, that you may or may not 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 Institutional Provider to the Non-Contracting Amount determined as payable by Medical Mutual.

Covered Person - the Certificate Holder, and if family coverage is in force, the Certificate Holder's Eligible Dependent(s) as defined in the Eligibility section of this Certificate.

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

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

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

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

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

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

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

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

Effective Date - 12:01 a.m. on the date when your coverage begins, as determined by your Group and Medical Mutual.

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

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

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

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

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

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

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

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

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure. Determination will be made by Medical Mutual at its sole discretion and will be final and conclusive.

Federally Eligible Individual -

- an individual who has had an 18 month period of Creditable Coverage with final coverage through a group plan, governmental plan or church plan. Coverage, after which there was a break of more than 63 days does not count in the period of Creditable Coverage. Creditable Coverage will be counted based on the standard method without regard to specific benefits;
- an individual who must apply within 63 days of the end of the termination date of your coverage under the group policy;
- an individual must not be eligible for coverage under a group health plan, Medicare or Medicaid;
- an individual must not have other health insurance coverage;
- an individual whose most recent prior coverage has not been terminated for nonpayment of premium or fraud; and
- if the individual elected COBRA coverage or Ohio extension of benefits coverage, the individual must exhaust all such continuation coverage to become a Federally Eligible Individual. Termination for non-payment of premium does not constitute exhausting such coverage.

Full-time Student - an Eligible Dependent who is enrolled at an accredited institution of higher learning. It must be certified annually that the student meets the institution's requirements for full-time status.

Hospital - an Institution that meets the specifications of Chapter 3727 of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio.

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

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

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

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

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

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

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

Medically Necessary (or Medical Necessity) - a 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 and excluding Biologically Based Mental Illness.

Negotiated Amount - the amount the Provider has agreed with Medical Mutual to accept as payment in full for Covered Services.

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

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

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

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

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

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

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

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

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

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

Non-PPO Network Coinsurance Limit - a specified dollar amount of Non-PPO Network Coinsurance expense for which you are responsible in each Benefit Period.

Non-PPO Network Deductible - an amount, usually stated in dollars, for which you are responsible each Benefit Period before Medical Mutual will start to provide benefits for services received from a Non-PPO Network Provider.

Non-PPO Network Provider - a Physician or Other Professional Provider, Contracting Hospital or Contracting Other Facility Provider, Home Health Care Agency or Hospice Provider that is not designated by Medical Mutual as a PPO 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 which require compensation from their patients. Other than incidentally, these facilities are not used as offices or clinics for the private practice of a Physician or Other Professional Provider. Medical Mutual will only provide benefits

for services or supplies for which a charge is made. Only the following Institutions which are defined below are considered to be Other Facility Providers:

- **Alcoholism Treatment Facility -** a facility that mainly provides detoxification and/or rehabilitation treatment for Alcoholism.
- **Ambulatory Surgical Facility -** a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a Physician and also includes nursing services.
- **Day/Night Psychiatric Facility -** a facility that is primarily engaged in providing diagnostic services and therapeutic services for the Outpatient treatment of Mental Illness and Biologically Based 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 of Chapter 3701.88 of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio and which provides nursing and other services as specified in the Home Health Care Services section of this Certificate. A Home Health Care Agency is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Hospice Facility -** a facility that provides supportive care for terminally ill patients as specified in the Hospice Services section of this Certificate.
- **Psychiatric Facility -** a facility that is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness and Biologically Based 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 and Biologically Based Mental Illness on an Inpatient basis. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must be provided under the supervision of a registered nurse.
- **Skilled Nursing Facility -** a facility that primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a Physician.

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

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

- registered nurse anesthetist; and
- Urgent Care Provider.

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

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

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

PPO Network Deductible - an amount, usually stated in dollars, for which you are responsible each Benefit Period before Medical Mutual will start to provide benefits, for services received from a PPO Network Provider.

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

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

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

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

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

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

Residential Treatment Facility -

- A facility that 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.
- The facility provides 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 meets 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.
- Residents do not require care in an acute or more intensive medical setting.

Rider - a document that amends or supplements your coverage.

Routine Services - Services not considered Medically Necessary.

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

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

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

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

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

Surgery -

- the performance of generally accepted operative and other invasive procedures;

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

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

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

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

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

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

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

ELIGIBILITY

Applying for Coverage

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

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

Eligible Dependents

An Eligible Dependent is:

- the Certificate Holder's spouse;
- the Certificate Holder or spouse's unmarried children, stepchildren, legally adopted children, children for whom either the Certificate Holder or Certificate Holder's spouse is the Legal Guardian or Custodian or any children who, by court order, must be provided health care coverage by the Certificate Holder or the Certificate Holder's spouse. To be considered Eligible Dependents, children's ages must fall within the age limit specified in the Schedule of Benefits, and they must receive over half of their support during the calendar year from the Certificate Holder unless coverage is being provided under court order.

Eligibility will continue past the age limit for Eligible Dependents who are unmarried and primarily dependent upon the Certificate Holder for support due to a physical handicap or mental retardation which renders them unable to work. This incapacity must have started before the age limit was reached and must be medically certified by a Physician. You must notify Medical Mutual 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, Medical Mutual may annually require further proof that the dependence and incapacity continue.

Effective Date

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

Changes in Coverage

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

A spouse and other dependents who become eligible by reason of marriage will be effective on the date of the marriage if an Application for their coverage is submitted to Medical Mutual within 31 days of the marriage. A newborn child or an adopted child will be covered for 31 days from birth or adoptive placement in the home. If payment of a specific premium is required to provide coverage for an additional child, that is, if you are changing from individual to family coverage, you must submit an Application to Medical Mutual within 31 days of birth in order to continue coverage beyond 31 days for the additional child. Coverage will continue for the adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

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 Application promptly as the date this new coverage begins will depend on when you apply.

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

Special Enrollment

If you were eligible to enroll under this Certificate and declined coverage because of other coverage and lose the other coverage through termination of employment, termination of the other coverage, termination of employer contributions

toward coverage, layoff or death of or divorce from your spouse, you and your Eligible Dependent(s) will be permitted to enroll during a special enrollment period. Enrollment must be supported by written documentation of the termination of the other coverage (including the effective date of the termination). Notice of intent to enroll must be provided to Medical Mutual within 31 days of the event with coverage to be effective on the date the other coverage terminated. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Eligible Dependents provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Your Identification Card

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

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

HEALTH CARE BENEFITS

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

Please refer to the Pre-Authorization of Non-PPO Network Benefits in the How Claims Are Paid section of the General Provisions for information regarding services received from Non-PPO Network Providers.

Allergy Testing and Treatments

Allergy testing performed and related to a specific diagnosis is covered. Desensitization treatments are also covered.

Ambulance Services

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

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

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

Transportation will also be covered when provided by a professional ambulance service for other than local ground transportation only when special treatment is required and the transportation is to the nearest Hospital qualified to provide the special treatment.

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

Case Management

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

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

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

Contraceptive Services

Your coverage includes benefits for the following contraceptive services:

- Intrauterine Devices(IUDs), including insertion and removal.

No other contraceptive services are covered.

Dental Services for an Accidental Injury

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

Diagnostic Services

A diagnostic service is a test or procedure performed, when you have specific symptoms, to detect or monitor your Condition. It must be ordered by a Physician or Other Professional Provider. Covered diagnostic services are limited to the following:

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

Drug Abuse and Alcoholism Services

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

- individual and group psychotherapy;
- psychological testing; and
- family counseling: counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Certificate. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient receiving treatment for Drug Abuse or Alcoholism.

Inpatient care must be approved by Medical Mutual prior to admission.

Residential care rendered by a Residential Treatment Facility is not covered.

Drugs and Biologicals

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

Drugs that can be covered under your supplemental prescription drug plan need to be obtained under your Pharmacy coverage.

Emergency Care Services

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

Health Education Services

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

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.

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

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

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

Hospice Services

Hospice services consist of health care services provided to a terminally ill Covered Person. Hospice services must be provided through a freestanding Hospice Facility or a hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Covered Person in a private residence.

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

The following Covered Services are considered hospice services:

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

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

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

Inpatient Hospital Services

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

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

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

Covered ancillary Hospital services include but are not limited to:

- operating, delivery and treatment rooms and equipment;
- Prescription Drugs;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. We will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded. **Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered;**
- anesthesia, anesthesia supplies and services;
- oxygen and other gases;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services;
- therapy services; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

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

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

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

- **diagnostic services;**
- **Custodial Care;**
- **rest care;**
- **environmental change;**
- **physical therapy; or**
- **residential treatment for psychiatric care, substance abuse or eating disorders.**

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

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

Infertility Services

The correction of a physical or medical Condition and diagnostic testing are Covered Services. Services related to artificial insemination and in vitro fertilization are also covered.

Maternity Services

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

Coverage for the Inpatient postpartum stay for the mother and the newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a caesarean section. It will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care.

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

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

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

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

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

Medical Care

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

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

If your 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.

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

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

Staff consultations required by Hospital rules are not covered.

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

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

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

Medical Supplies and Durable Medical Equipment

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

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

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

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

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

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

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

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

Covered DME includes:

- blood glucose monitors;
- respirators;
- home dialysis equipment;

- wheelchairs;
- hospital beds;
- crutches;
- mastectomy bra.

Non-covered equipment includes but is not limited to:

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

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

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

Non-covered devices include but are not limited to:

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

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

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

Covered prosthetic appliances include:

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

Non-covered appliances include but are not limited to:

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

Mental Health Care Services

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

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

Services for autism, developmental delay, mental deficiency or retardation, other than those necessary to evaluate or diagnose these Conditions, are not covered. Services for the treatment of attention deficit disorder are covered. **Residential care rendered by a Residential Treatment Facility is not covered.**

Your Physician or Other Professional Provider must certify that there is a reasonable likelihood that your treatment will be of substantial benefit and improvement is likely. The course of treatment which your Physician or Other Professional Provider recommends must be acceptable to Medical Mutual. Inpatient care must be approved by Medical Mutual prior to admission.

For limitations on benefits for Non-Biologically Based Mental Illness, please refer to your Schedule of Benefits.

Organ and Tissue Transplant Services

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

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

if such services take place during a transplant benefit period. A transplant benefit period is a per

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

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

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

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

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

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

Outpatient Institutional Services

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

Covered Institutional services include but are not limited to:

- operating, delivery and treatment rooms and equipment;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. We will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded. **Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered.**
- anesthesia, anesthesia supplies and services; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

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

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

Outpatient Therapy Services

Therapy services are services and supplies used to promote recovery from a Condition. Therapy services must be ordered by a Physician or Other Professional Provider to be covered. Covered Services are limited to the therapy services listed below:

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.

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

Chiropractic 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**.

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.

Hyperbaric Therapy - The provision of pressurized oxygen for treatment purposes. These services must be provided by a Hospital.

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; and
- that improvement will occur within 60 days of the first treatment.

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.

No benefits are provided once a patient can no longer significantly improve from treatment for the current Condition unless it is determined to be Medically Necessary by Medical Mutual.

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

Respiratory/Pulmonary Therapy - Treatment by the introduction of dry or moist gases into the lungs.

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

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

Physical Medicine and Rehabilitation Services

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

Routine and Wellness Services

Child Health Supervision Services and Well Child Care - Regardless of Medical Necessity, coverage for child health supervision services will be provided for Eligible Dependent children under the age of nine.

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

Immunizations - Regardless of Medical Necessity, immunizations are covered.

Routine Gynecological Services - The following services are covered:

- mammogram services; and
- PAP tests.

Routine Hearing Examinations - Routine hearing examinations are covered.

Routine Nonoperative Endoscopy - Regardless of Medical Necessity, minor nonoperative endoscopic procedures are Covered Services. Covered Services include anoscopy, colonoscopy, proctosigmoidoscopy and sigmoidoscopy.

Routine Physical Examinations - Routine physical examinations are covered.

Routine Testing - All routine laboratory, x-ray, diagnostic medical services are covered when performed on an Outpatient basis.

Routine Vision Examinations - Routine vision examinations are covered.

Skilled Nursing Facility Services

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

No benefits are provided:

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

Surgical Services

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

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

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

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

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

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

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

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

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

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

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

EXCLUSIONS

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

1. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
2. Not performed within the scope of the Provider's license.
3. Received from other than a Provider.
4. For Experimental or Investigational equipment, drugs, devices, services, supplies, tests, medical treatments or procedures.
5. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
6. For a Condition that occurs as a result of any act of war, declared or undeclared.
7. For which you have no legal obligation to pay in the absence of this or like coverage.
8. 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.
9. Received from a member of your Immediate Family.
10. Incurred after you stop being a Covered Person except as specified in the Benefits After Termination of Coverage section.
11. For the following:
    - physical examinations or services required by an insurance company to obtain insurance;
    - physical examinations or services required by a governmental agency such as the FAA and DOT;
    - physical examinations or services required by an employer in order to begin or to continue working;
    - premarital examinations;
    - screening examinations, except as specified; or
    - X-ray examinations made without film.
12. For a Condition occurring in the course of employment or for occupational injuries sustained by sole proprietors, if whole or partial benefits or compensation could be available under the laws of any governmental unit. This applies whether or not you claim such compensation or recover losses from a third party.
13. For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
14. Received in a military facility for a military service related Condition.
15. For Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss or weight loss Surgery), except as specified.
16. For Surgery to correct a deformity or birth defect for psychological reasons where there is no functional impairment.
17. For the removal of tattoos.
18. For dietary and/or nutritional guidance or training, except as specified.
19. For Outpatient educational, vocational or training purposes except as specified.
20. For treatment of Conditions related to an autistic disease of childhood, developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.
21. For topical anesthetics.
22. For arch supports and other foot care or foot support devices only to improve comfort or appearance which include, but are not limited to, care for flatfeet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails.
23. For weight loss drugs.

24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
25. For weight loss Surgery including complications related to this Surgery.
26. For water aerobics.
27. For residential care rendered by a Residential Treatment Facility.
28. For marital counseling.
29. For the medical treatment of sexual problems not caused by a biological Condition.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For Contraceptives, except as specified.
32. For contraceptive devices except as specified.
33. For reverse sterilization.
34. Incurred as a resu9.2 578.245 Tm(Ic4e(F)T4.22 61 0 9iupet1 0 4d(ansse)Tj6s0 9iupet1 0 4d)Tj1 0 0 1 89.27 593.6s0 9iupet5

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 we will send you a form, or you may print a claim form by going to www.medmutual.com/member.

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

Proof of Loss

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

Medical Mutual is not legally obligated to reimburse for Covered Services unless written or electronically submitted proof that Covered Services have been given to you is received. Proof must be given within 90 days of your receiving Covered Services or as soon as is reasonably possible. No proof can be submitted later than one year after services have been received.

How Claims are Paid

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

Benefit Period Deductible

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

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

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 Certificate Holder's family are injured in the same accident and each of the following conditions are met:

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

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

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

Copayments

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

Schedule of Benefits

The Deductibles, Coinsurance Limits and Non-PPO Network Coinsurance Limits that may apply will renew each Benefit Period. Some of the benefits offered in this Certificate have maximums. In addition, there may be a lifetime maximum for all Covered Services listed in this Certificate.

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

Your Financial Responsibilities

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

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

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

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

For Covered Services received from Non-PPO Network Providers, you may be responsible for the Non-PPO Network Coinsurance. The Non-PPO Network Coinsurance continues until your Non-PPO Network Coinsurance Limit is reached.

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. Example: Your coverage includes both a TMJ benefit limit of $1,000 per Benefit Period and a physical therapy visit limit of 10 visits per

Benefit Period. If you receive physical therapy for a TMJ diagnosis, the value of those services will be applied to both the TMJ maximum and the physical therapy visit limit.

Deductibles, Copayments, Coinsurance and amounts paid by other parties do not accumulate towards benefit maximums.

Provider Status and Direction of Payment

Medical Mutual has agreed to make payment directly to Contracting Institutional Providers and Participating Physicians and Other Professional Providers for Covered Services.

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

The choice of a Provider is yours. After a Provider performs a Covered Service, Medical Mutual will not honor your request to withhold claim payment. Medical Mutual does not furnish Covered Services but only pays for Covered Services you receive from Providers. Medical Mutual is not liable for any act or omission of any Provider. Medical Mutual has no responsibility for a Provider's failure or refusal to give Covered Services to you.

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

Medical Mutual is authorized to make payments directly to Providers who have performed Covered Services for you. Medical Mutual also reserves the right to make payment directly to you. When this occurs, you must pay the Provider and Medical Mutual is not legally obligated to pay any additional amounts. You cannot assign your right to receive payment to anyone else nor can you authorize someone else to receive your payments for you, including your Provider.

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

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

Pre-Authorization of Non-PPO Network Benefits

In some cases, Medical Mutual may determine that certain Covered Services can only be provided by a Non-PPO Network Provider. If Covered Services provided by a Non-PPO Network Provider are pre-authorized by Medical Mutual, benefits will be provided as if the Covered Services were provided by a PPO Network Provider.

To pre-authorize treatment by a Non-PPO Network Provider, your Physician must provide Medical Mutual with:

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

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

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

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, appeal information and a telephone number if you have any questions.

Time of Payment of Claims

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

Filing a Complaint

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

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

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

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

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

Filing an Appeal

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

To file an appeal, please call the Customer Service telephone number on your identification card or write a letter with the following information: Certificate Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or records, X-rays or photographs you would like considered in the appeal. Send or fax the letter to:

Medical Mutual
Member Appeals Unit
MZ: 01-4B-4809
P.O. Box 94580
Cleveland, Ohio 44101-4580
FAX: (216) 687-7990

To submit an appeal form electronically, go to Medical Mutual's Web site, www.MedMutual.com, under Members' section.

First Level Mandatory Appeal

Medical Mutual offers all members a first level mandatory appeal. Under state and federal law you must complete this first level of appeal before receiving an external review by the state Department of Insurance.

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

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

determination. All determinations of Medical Necessity that are based, in whole or in part, on a medical judgment are made by health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

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

The appeal procedures are as follows:

- You, your authorized representative or your Provider may request an appeal for urgent care. Urgent care claim appeals are typically those claims for medical care or treatment where withholding immediate treatment could seriously jeopardize the life or health of a patient or a patient's unborn child, or could affect the ability of the patient to regain maximum functions. The appeal must be decided with 72 hours of the request.
- You, your authorized representative or your Provider 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 Certificate. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date your received notice of denial.
- You, your authorized representative or your Provider 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 your received notice of the denial.

All notices of a denial of benefit will include the following:

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, then that information will be provided free of charge upon written request;
- if the claim was denied based on a Medical Necessity or Experimental treatment or similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be provided free of charge upon request;
- upon specific written request from you, provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Your Right to an Independent Review

You also have the right to request a review by the Department of Insurance in the state where your policy was issued. In Ohio, you may contact the Ohio Department of Insurance at the following address:

Ohio Department of Insurance
Consumer Services Division
50 W. Town Street, Third Floor - Suite 300
Columbus, Ohio 43215-4186

If Medical Mutual denied, reduced or terminated coverage for a health care benefit because Medical Mutual determined that the benefit was not covered under your Certificate, you have the right to request a review by the Ohio Department of Insurance. If the Ohio Department of Insurance reviews your case and cannot make a determination because it requires resolution of a medical issue, the Department will notify Medical Mutual of the need to offer you an external review. If the Department of Insurance reviews your case and determines that the health service is a covered benefit, Medical Mutual must either cover the service or allow you the opportunity of an external review.

External Review Process

In accordance with state law, Medical Mutual has also established an external review process to examine coverage decisions under certain circumstances. You may be eligible to have a decision reviewed by the external review process if you meet the following criteria:

1. Medical Mutual has denied, reduced, or terminated coverage for what would be a covered health care service except for the fact that Medical Mutual determined that the service is not Medically Necessary;

2. the proposed service, plus any ancillary services and follow-up care, will cost you $500 or more if it is not covered, except in the case of an expedited review; and
3. you have exhausted the internal appeal process.

You are NOT entitled to an external review if:

1. the Ohio Department of Insurance determined that the health care service is not a Covered Service under your Certificate; or
2. you have already had an external review for the same adverse determination and no new pertinent clinical information has been submitted.

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. However, if you have a condition that requires an expedited review, the review may be requested orally or electronically with a written confirmation not later than five days after the request is submitted. A request for an expedited external review should be made by contacting the Care Management Department at the number on the back of your identification card. It can be made by you or your Provider. Your Provider may not, however, request an external review without your prior written consent.

A request for a standard appeal for external review must be accompanied by written certification from your Provider that the proposed service, plus any ancillary services and follow-up care, will cost you $500 or more if the proposed service is not covered by Medical Mutual.

Expedited Review Process

A request for an expedited review must be certified by your Provider that your Condition could, without immediate medical attention, result in any of the following:

1. seriously jeopardize your life or health or your ability to regain maximum function or with respect to a pregnant woman, place the health of her unborn child in serious jeopardy; 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.

External reviews will be conducted by independent review organizations accredited by the Ohio Department of Insurance. You will not be required to pay for any part of the cost of the external review. 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.

In the case of an expedited review, the review panel will issue a written decision within three calendar days after you have submitted the request, with a possibility of extending to five calendar days with good cause. A written decision will be given within 30 days after you have submitted the request for all other external reviews. This written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. Medical Mutual will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Certificate.

External Review Process for Terminal Conditions

If you have a terminal Condition, you are eligible to have an external review if you meet all of the following criteria:

1. you have a terminal Condition that, according to the current diagnosis of your Physician, has a high probability of causing death within two years; and
2. your Physician certifies that one of the following situations applies to your terminal Condition;
    a. standard therapies have not been effective in improving your Condition;
    b. standard therapies are not medically appropriate for you;
    c. no standard therapy, covered by Medical Mutual, is more beneficial than a therapy recommended by your Physician or requested by you; and
3. your Physician has recommended a drug, device, procedure, or other therapy that your Physician certifies, in writing, is likely to be more beneficial to you, in the Physician's opinion, than standard therapies, or you have requested a therapy found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same Condition; and
4. you have been denied coverage by Medical Mutual for the drug, device, procedure or other recommended or requested therapy and have exhausted all internal appeals; and

5. the drug, device, procedure or other recommended or requested therapy would be a Covered Service except for Medical Mutual determination that the drug, device, procedure or other therapy is Experimental or Investigational.

You must request the review in writing unless your Physician determines that the therapy would be significantly less effective if not started immediately. You will not be required to pay for any part of the cost of the external review. The review panel will issue a written decision within three calendar days after you have submitted the request, with a possibility of extending up to five calendar days for good cause. This written decision will include a description of your condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. Medical Mutual will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Certificate.

Voluntary Second Level Appeal

If your first level mandatory appeal was denied, and you do not qualify for an External Review by the Ohio Department of Insurance, because the cost to you is less than $500, then you have the option of a voluntary second level appeal by Medical Mutual. All requests for appeal may be made by calling or writing to Customer Service. You may submit additional written comments, documents, records, X-rays, photographs and other information relating to the claim being appealed.

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

The voluntary second level of appeal provides a full and fair review of the claim, There will be a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the first level mandatory appeal. All determinations of Medical Necessity, that are based in whole or in part on medical judgment, are made by health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination of your claim.

Claim Review

Consent to Release Medical Information - Denial of Coverage

You consent to the release of medical information to Medical Mutual when you sign an Application.

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

Right to Review Claims

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

Physical Examination

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

Legal Actions

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

Coordination of Benefits

Coordination of Benefits is the procedure used to pay health care expenses when you or an Eligible Dependent is covered by more than one health care plan. Medical Mutual follows rules established by Ohio law to decide which health care plan pays first and how much the other health care plan must pay. The objective is to make sure the combined payments of all health care plans are no more than your actual bills.

When you or your Eligible Dependents are covered by another Group health care plan or an individual plan or policy in addition to this one, Medical Mutual will follow Ohio coordination of benefit rules to determine which health care plan is primary and which is secondary. You must submit all bills first to the primary health care plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary health care plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary health care plan.

Medical Mutual pays for health care only when you follow Medical Mutual's rules and procedures. If Medical Mutual's rules conflict with those of another health care plan, it may be impossible to receive benefits from both health care plans, and you will be forced to choose which health care plan to use.

Plans That Do Not Coordinate Benefits

Medical Mutual will pay benefits without regard to benefits paid by the following kinds of coverage:

- Medicaid;
- Group hospital indemnity coverages which pay less than $100 per day;
- school accident coverage; and
- some supplemental sickness and accident policies.

How Medical Mutual Pays As Primary

- When Medical Mutual is primary, Medical Mutual will pay the full benefit provided by your Certificate as if you had no other coverage.

How Medical Mutual Pays As Secondary

- When Medical Mutual is secondary, its payments will be based on the balance left after the primary health care plan has paid. Medical Mutual will pay no more than that balance. In no event will Medical Mutual pay more than it would have paid had Medical Mutual been primary.
- Medical Mutual will pay only for health care services that are covered under this Certificate.
- Medical Mutual will pay only if you have followed all of Medical Mutual's procedural requirements, including precertification.
- Medical Mutual will pay no more than the "allowable expense" for the health care involved. Medical Mutual will use the primary health care plan's allowable expense. That may be less than the actual bill.

Which Health Care Plan is Primary?

To decide which health care plan is primary, Medical Mutual has to consider both the coordination of benefits provisions of the other health care plan and which member of your family is involved in a claim. The primary health care plan will be determined by the first of the following which applies:

- **Non-coordinating Plan -** If you have another Group plan which does not coordinate benefits, it will always be primary.
- **Employee -** The plan which covers you as an employee (neither laid off nor retired) is always primary.
- **Children (Parents Divorced or Separated) -** If the court decree makes one parent responsible for health care expenses, that parent's plan is primary.

  If the court decree gives joint custody and does not mention health care, Medical Mutual follows the birthday rule as discussed below.

  If neither of those rules applies, the order will be determined in accordance with the Ohio Department of Insurance rule on coordination of benefits.

- **Children and the Birthday Rule -** When your children's health care expenses are involved, Medical Mutual follows the "birthday rule". The health care plan of the parent with the first birthday in a calendar year is always primary for the children. For example: If your birthday is in January and your spouse's birthday is in March, your health care plan will be primary for all of your children.

  However, if your spouse's health care plan has some other coordination of benefits rule (for example, a "gender rule" which says the father's health care plan is always primary), Medical Mutual will follow the rules of that health care plan.

- **Other Situations -** For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Department of Insurance rule on coordination of benefits.

Coordination Disputes

If you believe that Medical Mutual has not paid a claim properly, you should first attempt to resolve the problem by contacting Medical Mutual. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

Provision Enforcement

Medical Mutual will coordinate benefits to the extent that Medical Mutual is informed by you or some other person or organization of your coverage under any other health care plan. Medical Mutual is not required to determine if and to what extent you are covered under any other health care plan.

In order to apply and enforce this provision or any provision of similar purpose of any other health care plan, it is agreed that:

- any person claiming benefits described in this Certificate will furnish Medical Mutual with any information Medical Mutual needs; and
- Medical Mutual may, without the consent of or notice to any person, release to or obtain from any source any necessary information.

Facility of Payment

If payment is made under any other health care plan which Medical Mutual should have made under this provision, then Medical Mutual has the right to pay whoever paid under the other health care plan; Medical Mutual will determine the necessary amount under this provision. Amounts so paid are benefits under this Certificate and Medical Mutual is discharged from liability to the extent of such amounts paid for Covered Services.

Right of Recovery

If Medical Mutual pays more for Covered Services than this provision requires, Medical Mutual has the right to recover the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure Medical Mutual's right to recover the excess payment.

Subrogation and Right of Reimbursement

This provision applies when Medical Mutual pays benefits for personal injury and you may have the right to recovery damages from another. Acceptance of Medical Mutual benefits for Covered Services constitutes your acceptance and acknowledgment of this provision.

Subrogation

Medical Mutual is subrogated to all your rights of recovery to the extent of the benefits it pays or provides for Covered Services for an illness or injury for which you may be entitled to recover payment from any other person. Medical Mutual is subrogated to any right you have to recover from the person who caused the illness or injury, that person's insurer or under any "Uninsured Motorist", "Underinsured Motorist", "Medical Payments", "No-Fault" or other similar coverage provisions. Medical Mutual's right of subrogation applies with equal force to any and all state, federal or common law claims of survivors, wrongful death, consortium or other similar claims. However, Medical Mutual's right of subrogation shall not exceed the amount of the benefits paid or to be paid in the future by Medical Mutual.

Medical Mutual's subrogation right has first priority to any recovery and takes priority over the injured party, their attorney or any other person or entity with a claim, right or lien on the recovery. Medical Mutual's subrogation right shall not be reduced for any attorney fees or costs Incurred by you or any other party.

Medical Mutual's right to subrogation will apply even if you have not been made whole, are not fully compensated or only partially recover for your loss.

Reimbursement

If you recover damages from any party or through any coverage named above, regardless of how you, your legal representative or any other party characterize the recovery, you must hold in trust for Medical Mutual, the whole proceeds of the recovery and must reimburse Medical Mutual to the extent of payments made within 14 days of its receipt. Medical Mutual has a constructive trust, equitable lien and other equitable rights on the entire fund of money recovered which can be asserted against any parties who may have possession of a portion or all of the fund.

Medical Mutual's reimbursement right has first priority to any recovery and takes priority over the injured party, their attorney or any other person or entity with a claim, right or lien on the recovery. Medical Mutual's reimbursement right shall not be reduced for any attorney fees or costs Incurred by you or any other party. You will be responsible for payment of any expenses, including attorney fees and court costs, Incurred by Medical Mutual to enforce its right of reimbursement.

Any other person or entity with a claim, right or lien on the recovery, Medical Mutual's right to reimbursement will apply even if you have not been made whole, are not fully compensated or only partially recover for your loss.

Your Duties

You must provide Medical Mutual any information requested by Medical Mutual within five (5) days of the request.

You must notify Medical Mutual 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 Medical Mutual in the investigation, settlement and protection of Medical Mutual's rights.

You must send Medical Mutual 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 Medical Mutual is notified, in writing, at least 30 days before such settlement or compromise and Medical Mutual agrees to it in writing.

Discretionary Authority

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

Changes In Benefits or Provisions

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

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

Termination of Coverage

How and When Your Coverage Stops

Your coverage stops:

- By termination of the Group Contract including termination for non-payment. This automatically ends all of your coverage and you are not offered a conversion privilege. It is the responsibility of your Group to notify you of such termination.
- On the date a Covered Person stops being an Eligible Dependent or if coverage is extended by your Group for Full-time Student status, on the date the Full-time Student status ends. You are responsible for notifying Medical Mutual immediately of any change to the eligibility status of a Full-time Student.
- On the date that the Certificate Holder becomes ineligible, when a Covered Person stops being an eligible Certificate Holder.
- At the end of the period for which the premium was made when a Covered Person does not pay the next required contribution.
- On the day a final decree of divorce, annulment or dissolution of the marriage is filed, a Certificate Holder's spouse will no longer be eligible for coverage, subject to any available conversion offer.
- Immediately upon notice if:
  - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
  - a Covered Person intentionally misrepresents a material fact provided to Medical Mutual or commits fraud or forgery.

Certificate of Creditable Coverage

If any Covered Person's coverage would end and your employer's group policy is still in effect, you and your covered Eligible Dependents will receive a certificate of creditable coverage that shows your period of coverage under Medical Mutual.

Federal Continuation Provisions - COBRA

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

When You Are Eligible for COBRA

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

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

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

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

1. the death of the Certificate Holder;

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

Notice Requirements

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

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

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

How Long COBRA Coverage Will Continue

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

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

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

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

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

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.

Conversion Privilege

If your Group's Contract is in effect but you are no longer eligible for coverage, you may be eligible for coverage under Medical Mutual's conversion policy if any of the following events occur:

- the Certificate Holder is no longer employed;
- the Certificate Holder dies;
- an Eligible Dependent child marries, attains the dependent age limit, is no longer a student or is no longer dependent upon the Certificate Holder or spouse;
- you and your spouse get a divorce, annulment, or a dissolution; or
- the maximum time allowed for continuation coverage under COBRA or other state or federal laws has been reached.

In addition, you need to be advised of what qualifies you to meet the requirements of a Federally Eligible Individual. Please refer to the definition of a Federally Eligible Individual found in the Definitions section at the beginning of this Certificate. Special non-group plans required by state law are available to Federally Eligible Individuals.

The conversion coverage may be different from the coverage provided under this Contract or your continuation coverage under COBRA or other state or federal laws. You must apply, in writing, to Medical Mutual for this conversion coverage no later than 31 days after your coverage under this Contract stops. No evidence of insurability will be required to obtain a conversion policy.

You must pay for conversion coverage from the date you stop being a Covered Person under this Contract. If you pay from that date, your coverage under the conversion policy will start on the date the coverage under this Contract stops.

Conversion is not permitted in the following situations:

- your Group has cancelled Medical Mutual coverage;
- your Group has been terminated for non-compliance with underwriting regulations or non-payment of premium;
- you are being removed from the Group's coverage because you were not eligible to be enrolled in the Group's program; or
- Medical Mutual has declined to renew your Group on its anniversary date.

RETAIL AND HOME DELIVERY PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Benefit Period	Calendar Year
Dependent Age Limit	Please refer to your medical Schedule of Benefits
Days Supply	30 days for retail Prescription Drugs or 90 days for Home Delivery Prescription Drugs

The following Prescription Drug Covered Services are not subject to the Prescription Drug Copayments, each time services are received from a Participating Drug Provider or Contracting Home Delivery Pharmacy:

diabetic supplies including over-the-counter supplies[1], insulin, syringes/needles, glucomonitors, and glucometers.

MAXIMUM BENEFIT PAYABLE PER LIFETIME PER COVERED PERSON
Benefits provided under this Prescription Drug coverage will accumulate towards the medical lifetime maximum.

COPAYMENTS FOR RETAIL PRESCRIPTION DRUG COVERED SERVICES		
TYPE OF SERVICE	**For Prescription Drug Covered Services received from a Participating Drug Provider[2]**	**For Prescription Drug Services received from a Non-Participating Drug Provider[2]**
	YOU PAY THE FOLLOWING	
Generic Prescription Drugs	$5 Copayment	$5 Copayment
Brand Name Formulary and Non-Formulary Prescription Drugs for which a Generic Prescription Drug is available or manufactured but not chosen	$5 Copayment, plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug	$5 Copayment, plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug
Brand Name Formulary Prescription Drugs for which no Generic Prescription Drug is available or manufactured	$10 Copayment	$10 Copayment
Brand Name Non-Formulary Prescription Drugs for which no Generic Prescription Drug is available or manufactured	$20 Copayment	$20 Copayment

COPAYMENTS FOR HOME DELIVERY PRESCRIPTION DRUG COVERED SERVICES		
TYPE OF SERVICE	**For Prescription Drug Covered Services received from a Contracting Home Delivery Pharmacy[2]**	**For Prescription Drug Services received from a Non-Contracting Home Delivery Pharmacy[2]**
	YOU PAY THE FOLLOWING	
Generic Prescription Drugs	$5 Copayment	Not Covered[3]
Brand Name Formulary and Non-Formulary Prescription Drugs for which a Generic Prescription Drug is available or manufactured but not chosen	$5 Copayment, plus the difference between the cost of the Generic Prescription Drug and the cost of the Brand Name Prescription Drug	Not Covered [3]
Brand Name Formulary Prescription Drug, for which no Generic Prescription Drug is available or manufactured	$10 Copayment	Not Covered [3]
Brand Name Non-Formulary Prescription Drug, for which no Generic Prescription Drug is available or manufactured	$20 Copayment	Not Covered [3]

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[1] Over-the-counter supplies require a Prescription Order.

[2] Please refer to the Prescription Drug Benefits section for additional information.

[3] Benefits for Prescription Drugs are available when obtained from a retail Pharmacy.

PRESCRIPTION DRUG RIDER

This Rider amends your Certificate. Except as amended, your Certificate remains unchanged. When coverage under your Certificate ends, coverage under this Rider also ends. If a lifetime maximum for all Covered Services is specified in the medical Schedule of Benefits, Prescription Drug benefits provided under this Rider will accumulate towards the medical lifetime maximum.

PRESCRIPTION DRUG BENEFITS

Medical Mutual will provide benefits for Medically Necessary Prescription Drug Covered Services. All Prescription Drugs and refills must be prescribed by a Physician. Medical Mutual may require precertification of certain Prescription Drugs. They must be dispensed for your Outpatient use. A Prescription Drug is a medicinal substance which is required to bear the label: "Caution: Federal Law prohibits dispensing without a prescription." This includes injectable medications as well as compounded medications which contain at least one such medicinal substance. Benefits will be provided based on the Prescription Drug Lesser Amount, minus the Prescription Drug Copayment as described below and in the Prescription Drug Schedule of Benefits.

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

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

Medical Mutual will also provide benefits for the Prescription Drug Lesser Amount, minus the Prescription Drug Copayment, for injectable insulin. Injectable insulin is covered whether or not it is prescribed. Insulin needles and syringes are Covered Services only when they are dispensed with and included on the same Prescription Order as the injectable insulin.

Benefits are not provided for Prescription Drugs or injectable insulin if the Prescription Drug Lesser Amount is less than the Prescription Drug Copayment. In this case, your liability is limited only to the Prescription Drug Lesser Amount.

Your coverage also provides benefits for oral and injectable contraceptives, implantable contraceptives and transdermal patches. Contraceptive devices, including but not limited to, intrauterine devices (IUDs) are not covered.

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

Coverage during active military duty:

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

Prescription Drug Covered Services and refills received from a Participating Drug Provider:

- Medical Mutual covers the remaining liability for the Prescription Drug Lesser Amount after you have paid the Prescription Drug Copayment. You present your identification card to the Participating Drug Provider and pay only the Prescription Drug Copayment to obtain the Covered Services. The Participating Drug Provider will then bill Medical Mutual directly and Medical Mutual will pay the Participating Drug Provider.

Prescription Drug Covered Services and refills received from a Non-Participating Drug Provider:

- Medical Mutual will provide 75% of the Prescription Drug Lesser Amount, minus the Prescription Drug Copayment, as indicated in the Prescription Drug Schedule of Benefits. You must pay the Pharmacy the full amount of the bill for the Prescription Drug at the time of purchase. You must then file a claim form with Medical Mutual and payment will be made directly to you for 75% of the Prescription Drug Lesser Amount, minus the Prescription Drug Copayment. You may be responsible for any amount in excess of the Prescription Drug Covered Charges.

HOME DELIVERY PRESCRIPTION DRUG BENEFITS

Benefits for Home Delivery Prescription Drugs provide the convenience of receiving Prescription Drugs delivered directly to your home. A Home Delivery Prescription Drug is a Prescription Drug which can be provided by a Contracting Home Delivery Pharmacy and must be taken for an extended period of time in order to treat a certain medical Condition. Medical Mutual will provide benefits for the Prescription Drug Negotiated Amount, minus the Prescription Drug Copayment, for Medically Necessary Home Delivery Prescription Drugs and refills as described below and in the Prescription Drug Schedule of Benefits.

Benefits are not provided for Home Delivery Prescription Drugs, supplies or injectable insulin if the Contracting Home Delivery Pharmacy charge is less than the Prescription Drug Copayment. In this case, your liability is limited only to the Contracting Home Delivery Pharmacy charge.

Prescription Drug Covered Services and refills received from a Contracting Home Delivery Pharmacy:

To receive Home Delivery Prescription Drug benefits, mail your Prescription Order and the Prescription Drug Copayment amount which is specified in the Prescription Drug Schedule of Benefits to a Contracting Home Delivery Pharmacy. No benefits are payable if your Prescription Order is sent to other than a Contracting Home Delivery Pharmacy.

The Contracting Home Delivery Pharmacy will fill your Prescription Order and send you a supply for the number of days indicated in the Prescription Drug Schedule of Benefits. The Contracting Home Delivery Pharmacy will dispense the medication and mail it to you within 72 hours. If the Contracting Home Delivery Pharmacy fails to send you the Home Delivery Prescription Drug within ten days after you mailed in your Prescription Order, you may call the Contracting Home Delivery Pharmacy directly to determine the status of the Prescription Order.

A Generic Prescription Drug will be dispensed unless a Brand Name Prescription Drug is requested by your Physician or if a Brand Name Prescription Drug is not available.

EXCLUSIONS

In addition to the exclusions and limitations explained in the Prescription Drug Benefits section and your Certificate, coverage is not provided for services and supplies:

1. For contraceptive devices which include, but are not limited to, IUD's, diaphragms and cervical caps.
2. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.
3. For allergy sera.
4. For immunization agents, vaccines and biologicals.
5. For weight loss drugs.
6. For drugs dispensed for cosmetic purposes; used solely for beautifying or altering one's appearance in the absence of any underlying Condition.
7. For therapeutic devices.
8. For artificial appliances.
9. For disposable insulin needles and syringes which are not prescribed.
10. For hypodermic needles, syringes or comparable devices or appliances, except as specified.
11. For over the counter drugs, vitamins or herbal remedies.
12. For drugs you can buy without a Prescription Order.
13. For more than the number of Prescription Drug refills specified by the Physician.
14. For any refill of a Prescription Drug dispensed after one year from the date of the original Prescription Order.
15. For charges for more than the days supply of a Prescription Drug, as specified in the Prescription Drug Schedule of Benefits.
16. Incurred or received after you stop being a Covered Person.
17. For a Prescription Drug which is entirely consumed or administered at the time and place where the Prescription Order is issued.
18. For fees for administering or injecting Prescription Drugs.

19. For non-covered services or services specifically excluded in the text of this Rider.

DEFINITIONS

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

Brand Name Formulary Prescription Drug - a Brand Name Prescription Drug that is included in Medical Mutual's list of preferred Prescription Drugs.

Brand Name Non-Formulary Prescription Drug - a Brand Name Prescription Drug that is not included in Medical Mutual's list of preferred Prescription Drugs.

Brand Name Prescription Drug - a Prescription Drug that has been patented with the Brand Name and is produced by the original manufacturer under that Brand Name.

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

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

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

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

Non-Participating Drug Provider - a Pharmacy or Physician who does not have an agreement with Medical Mutual directly or indirectly to provide services.

Participating Drug Provider - a Pharmacy or Physician who has an agreement with Medical Mutual or with a vendor who has a contract with Medical Mutual to provide Prescription Drug services.

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

Prescription Drug Coinsurance - a percentage of the Prescription Drug Lesser Amount for which you are responsible.

Prescription Drug Copayment - an amount, usually stated in dollars, for which you are responsible before Medical Mutual will start to provide benefits for a Prescription Order or refill.

Prescription Drug Covered Charges - an amount which Medical Mutual determines to be reasonable for a covered Prescription Drug.

Prescription Drug Lesser Amount - for Participating Drug Providers, the Prescription Drug Lesser Amount means the lesser of the Prescription Drug Negotiated Amount or the Prescription Drug Covered Charges. For Non-Participating Drug Providers, the Prescription Drug Lesser Amount means the Prescription Drug Covered Charges.

Prescription Drug Negotiated Amount - the amount the Provider has agreed with Medical Mutual to accept as payment in full for Covered Services.

The Prescription Drug Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings, 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 Prescription Drug Negotiated Amount will be based upon the agreement or arrangement Medical Mutual has with the vendor and not upon the vendor's actual negotiated price with the Provider, subject to the further conditions and limitations set forth herein.

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

VISION SCHEDULE OF BENEFITS

Benefit Period	Calendar year
Dependent Age Limit	The 19th birthday or the 24th birthday if the dependent is a Full-time Student

The following Covered Services are subject to a Copayment each time services are received:

vision examinations, $7.50 Copayment

lenses and basic frames, $12.50 Copayment

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

Type of Service	**Benefit Maximums**
Vision Examinations	One exam per Benefit Period
Frames	One Frame per two Calendar years
Lenses	One pair per Benefit Period
Contact Lenses	One pair per Benefit Period

Notes

1. Benefits available for Lenses may be used for Contact Lenses in lieu of Lenses.

VISION PAYMENT SCHEDULE	
Type of Service	**You Pay the Following**
Contact Lenses	0% of the Traditional Amount
For all other Covered Services	0% of the Traditional Amount.

VISION RIDER

This Rider amends your Certificate. Except as amended, your Certificate remains unchanged. When coverage under your Certificate ends, coverage under this Rider also ends.

VISION 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.

These services do not require prior authorization from your Primary Care Physician.

The following are Covered Services:

Vision Examinations - Regardless of Medical Necessity, Medical Mutual will cover the following services when performed as part of a vision examination:

- a case history;
- an external examination of the eye and adnexa;
- an ophthalmoscopic examination;
- a determination of refractive status;
- binocular balance testing;
- tonometry, as needed;
- gross visual fields;
- color vision testing;
- summary findings; and
- recommendations including prescribing Lenses.

Prescribed Lenses and Frames - Medical Mutual will cover the following services only when performed to obtain prescribed Lenses and Frames:

- facial measurements and determination of interpupillary distance;
- assistance in choosing Frames;
- verification of Lenses as prescribed; and
- after-care for a reasonable period of time for fitting and adjustment.

The total payment available for Lenses, Frames and the above services is limited to the amount available for Lenses and Frames listed in the Schedule of Benefits.

Prescribed Contact Lenses - Please refer to your Vision Schedule of Benefits for information on how Contact Lenses will be covered.

EXCLUSIONS

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

1. For diagnostic services, drugs or medications not part of a vision examination.
2. For an eye examination or materials ordered as a result of an eye examination prior to your Effective Date.
3. For Lenses which are not prescribed.
4. For medical or surgical treatment.

5. For the replacement of Lenses or Frames except as specified in the Schedule of Benefits.
6. For safety glass and safety goggles.
7. That Medical Mutual determines are special or unusual; such as orthoptics, vision training and low vision aids.
8. For tints other than Number One or Two.
9. For tints with photosensitive or antireflective properties.
10. For non-covered services or services specifically excluded in the text of this Rider.

GENERAL PROVISIONS

How Claims are Paid

Coinsurance

You may be responsible for Coinsurance amounts subject to any limitations set forth in your Schedule of Benefits.

Schedule of Benefits

The Schedule of Benefits shows your financial responsibility for Covered Services. Medical Mutual covers the remaining liability for Covered Charges after you have paid the amounts indicated in the Schedule of Benefits.

Your Financial Responsibilities

Your financial responsibilities may include Coinsurance amounts, Non-Covered Charges and Billed Charges for all services and supplies after benefit maximums have been reached.

You may also be responsible for Excess Charges if your Provider does not accept the Traditional Amount as payment in full.

Coinsurance and amounts paid by other parties do not accumulate towards benefit maximums.

DEFINITIONS

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

Contact Lenses - corrective Lenses, ground or molded, as prescribed by a Physician or Optometrist to be directly fitted to your eye.

Frame - standard eyeglasses excluding the Lenses.

Lenses - clear glass or plastic single vision, bifocal or trifocal corrective materials which are ground as prescribed by a licensed Provider.

Optician - an Other Professional Provider lawfully engaged in dispensing Lenses prescribed by a Physician or Optometrist.

Optometrist - an Other Professional Provider licensed to practice optometry.