MAYFIELD CITY SCHOOLS

Group Number
678059-003, 103

Vision Certificate

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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 CERTIFICATE

This Certificate describes the vision 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)

HOW TO USE YOUR CERTIFICATE

This Certificate describes your vision benefits. Please read it carefully.

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

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

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

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

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

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

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.

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.

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.

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. 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. For Experimental or Investigational equipment, drugs, devices, services, supplies, tests, medical treatments or procedures.
4. For diagnostic services, drugs or medications not part of a vision examination.
5. For medical or surgical treatment.
6. That Medical Mutual determines are special or unusual; such as orthoptics, vision training and low vision aids.
7. For the replacement of Lenses or Frames except as specified in the Schedule of Benefits.
8. For Lenses which are not prescribed.
9. For safety glass and safety goggles.
10. For tints other than Number One or Two.
11. For tints with photosensitive or antireflective properties.
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. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
14. For which you have no legal obligation to pay in the absence of this or like coverage.
15. 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.
16. For an eye examination or materials ordered as a result of an eye examination prior to your Effective Date.
17. Incurred or received after you stop being a Covered Person.
18. Received from a member of your Immediate Family.
19. 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.
20. For a Condition that occurs as a result of any act of war, declared or undeclared.
21. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
22. Received in a military facility for a military service related Condition.
23. For fraudulent or misrepresented claims.
24. For non-covered services or services specifically excluded in the text of this Certificate.

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

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

Proof of Loss

Proof of loss is a claim for payment of vision 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 is not legally obligated to reimburse for Covered Services unless Medical Mutual receives written or electronically submitted proof that Covered Services have been given to you. 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.

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.

Provider Status and Direction of Payment

Medical Mutual has agreed to make payment directly to Participating Physicians and Other Professional Providers.

Some of Medical Mutual's contracts with 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, Coinsurance and benefit maximums 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 and retains the sole right to choose which Providers it will contract with, and on what terms, and to amend and terminate those contracts. Medical Mutual has and retains the sole right to designate Providers as Participating.

You authorize Medical Mutual to make payments directly to Providers who have performed Covered Services for you. Medical Mutual also reserves the right to make payment directly to you. When this occurs, you must pay the Provider and 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.

If Medical Mutual has incorrectly paid for services or it is later discovered that payment was made for services which 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 Participating or Non-Participating is not a statement about their abilities.

Explanation of Benefits

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

Time of Payment of Claims

Benefits will be provided under this Certificate within 30 days after receipt of a completed claim. To have a payment or denial related to a claim reviewed, you must send a written request to 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; 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 any action is taken in a court of law. .

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 request 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 your Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations of Medical Necessity that are based, in whole or in part, on a medical judgment are made by health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

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

The appeal procedures are as follows:

- 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 vision 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 you 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 vision care that has already been provided. The post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of 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
- your right to bring a civil action under federal law following the denial of a claim upon review
- 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 in applying the terms of the plan to the circumstances will be provided free of charge upon request;
- upon specific written request from you, provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Voluntary Second Level Appeal

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

This second level appeal is voluntary, which means this level of appeal is available, but not required, before pursuing any civil action. Any statute of limitation will be applicable during the period of the voluntary appeal process.

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

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

Claim Review

Consent to Release Medical Information - Denial of Coverage

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

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 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. If Medical Mutual's allowable expense is lower than the primary plan's, 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

If Medical Mutual provides benefits for Covered Services and you have the right to recover from another person, organization or insurer as a result of a negligent or wrongful act, Medical Mutual assumes your legal rights to any recovery of Incurred expenses. For the purposes of this section, "insurer" shall include, but is not limited to, (1) any insurer of any third party, (2) any insurer providing uninsured or under-insured motorist coverage, and (3) your own insurer other than Medical Mutual.

To the extent Medical Mutual provides benefits for Covered Services, you must repay Medical Mutual amounts recovered by suit, settlement or otherwise from any person, organization or insurer.

You have the legal obligation to help Medical Mutual in all possible ways when Medical Mutual tries to recover these amounts.

You must give Medical Mutual information and assistance and sign the necessary documents to help enforce Medical Mutual's rights. You must not do anything which might limit Medical Mutual's rights.

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 that a Covered Person stops being an Eligible Dependent.
- At the end of the month in which the Certificate Holder becomes ineligible, when a Covered Person stops being an eligible Certificate Holder.
- At the end of the period for which payment was made when a Covered Person does not pay the required contribution.
- On the last day of the month in which 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.
- Upon notice if:
  - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
  - a Covered Person materially misrepresents information provided to Medical Mutual or commits fraud or forgery.

Continuation of Coverage

If any Covered Person's Group coverage would otherwise end, you and your Eligible Dependents may be eligible for continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You may also be eligible to continue benefits under other state or federal laws as a result of employment termination. It is your Group's responsibility to advise you of your COBRA rights and to provide you with the required documents to complete upon the qualifying event.

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

DEFINITIONS

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 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.

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.

Coinsurance - a percentage of the Traditional Amount for Covered Services for which you are responsible.

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

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

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.

Covered Charges - the Billed Charges for Covered Services.

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 the Vision Benefits section of this Certificate for which Medical Mutual will provide benefits, as listed in the Schedule of Benefits.

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

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

Excess Charges - the amount of Billed Charges less Non-Covered Charges in excess of the Traditional Amount for 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.

Frame - standard eyeglasses excluding the Lenses.

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.

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.

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.

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

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;
- 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 Prescription Drugs, this means the Prescription Drug is cost effective compared to alternative Prescription Drugs which will produce comparable effective clinical results.

Contact Lenses are considered Medically Necessary when:

- necessary following cataract Surgery;
- visual acuity cannot be corrected to 20/70 in either eye with other Lenses;or
- required for the treatment of anisometropia or keratoconus.

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

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.

Optician - a person lawfully engaged in dispensing Lenses prescribed by a Physician or Optometrist.

Optometrist - a person licensed to practice optometry.

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

- Optometrist; and
- Optician.

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.

Provider - Physician or Other Professional Provider.

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.