STARK COUNTY SCHOOLS
Council of Governments (COG)

HEALTH BENEFITS PLAN

Group Numbers
418470
418472
21804M

EFFECTIVE 4.3.2025

NOTICE:

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

MEDICAL MUTUAL SERVICES, LLC
AULTCARE INSURANCE COMPANY

DENTAL NOTICE:

IF YOUR PLAN OFFERS DENTAL COVERAGE THROUGH STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS AND YOU HAVE ELECTED TO HAVE DENTAL COVERAGE, PLEASE SEE THE DENTAL SECTION OF THIS BOOK FOR YOUR DENTAL BENFITS.

VISION NOTICE:

IF YOUR PLAN OFFERS VISION COVERAGE THROUGH STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS AND YOU HAVE ELECTED TO HAVE VISION COVERAGE, PLEASE SEE THE VISION SECTION OF THIS BOOK FOR YOUR VISION BENFITS.

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PPO SCHEDULE OF BENEFITS

To receive the highest level of benefits at the lowest Out-of-Pocket Maximum expense, Covered Services must be provided by Network Providers. These Providers (and other Providers with whom we have a contract) have agreed to accept a specific payment amount for their services. Non-Contracting Providers may charge a higher amount, and you may be responsible for any balance due between the Provider's charge and the Allowed Amount. This difference is often referred to as "balance billing" and is in addition to any Deductibles, Copayments, Coinsurance, and Non-Covered Charges for which you are responsible.

All benefits are calculated based upon the applicable Allowed Amount or Non-Contracting Amount, not the Provider's charge. Refer to "How Claims are Paid," General Provisions, for additional information.

Non-Contracting Providers are prohibited from balance billing you for the services shown below. Refer to "No Surprise Billing," under General Provisions, for more information.

- Emergency Services
- Air ambulance Covered Services received from a Non-Network or Non-Contracting Provider
- Unanticipated Covered Services received from a Non-Network or Non-Contracting Provider at a Network or Contracting Hospital or ambulatory surgical center.

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

BENEFIT PERIOD AND DEPENDENT AGE LIMIT	
Benefit Period	January 1st through December 31st
Dependent Age Limit	The end of the month of the 26th birthday

PPO COMPREHENSIVE MAJOR MEDICAL BENEFIT		
	In Network	**Out of Network**
Deductible per Benefit Period		
If you have single coverage:	$350	$700
If you have family coverage:	$700	$1,400
	In Network	**Out of Network**
Coinsurance Limit per Benefit Period		
If you have single coverage:	$1,050	$2,100
If you have family coverage:	$2,100	$4,200
	In Network	**Out of Network**
Out-of- Pocket Limit per Benefit Period (sum of deductible and coinsurance)		
If you have single coverage:	$1,400	$2,800
If you have family coverage:	$2,800	$5,600
	In Network	**Out of Network**
Non-Emergency Care Out of Pocket Limit ($250 copayment and coinsurance)		
If you have single coverage:	$7,700	$7,500
If you have family coverage:	$15,400	$15,000
Network Maximum Out-of-Pocket Limit not to exceed the ACA maximum $9,100/$18,200		

Penalty for failure to obtain Preauthorization for services received from a Non-Contracting Institutional Provider	$200 (Not applied to the Deductible or Out-of-Pocket Maximum)

A family plan with two kinds of Deductibles and Out-of-Pocket Maximums: one for an individual family member and one for the whole family. With family coverage, each Covered Person's Out-of-Pocket Maximum will not exceed the Network Out-of-Pocket Maximum for single coverage shown on the Schedule of Benefits.

Prescription Drug benefits that accumulate toward the Out-of-Pocket Maximum are provided under a separate arrangement between the Group and the Group's pharmacy benefits manager Caremark and are not administered by the medical Claims Administrator. Prescription Drug benefits can be found on page 64.

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

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

Any amounts applied to your Network Deductible or Network Coinsurance Limit and Out-of-Pocket Maximum will also be applied to your Non-Network Deductible or Non-Network Coinsurance Limit and Out-of-Pocket Maximum. Any amounts applied to your Non-Network Deductible or Non-Network Coinsurance Limit and Out-of-Pocket Maximum will also be applied to your Network Deductible or Network Coinsurance Limit and Out-of-Pocket Maximum.

It is important that you understand how The Claims Administrator calculates your responsibilities under this Benefit Book. Please consult the “HOW CLAIMS ARE PAID” section for necessary information.

To receive maximum benefits, you must use Network Providers. Network Providers may change. The Claims Administrator will tell you 60 days before a Network Hospital becomes Non-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-Network Hospital in an emergency.

BENEFIT MAXIMUMS PER COVERED PERSON	
(per Benefit Period unless otherwise shown) The visit and/or frequency limit shown does not apply to the treatment of Mental Illness, Drug Abuse or Alcoholism.	
Hearing aids for Covered Persons under age 22, obtained from a PPO Network Provider or Non-PPO Network Provider	One per ear, up to $2,500 every 48 months. (Related Services are not subject to the $2,500 maximum)
Outpatient Professional Occupational and Physical Therapy Services and Chiropractic Visits	25 visits, then subject to medical review (combined)
Outpatient Speech Therapy Services	10 visits, then subject to medical review
Preventive Chest X-ray, Complete Blood Count (CBC), Electrocardiogram (EKG), Comprehensive Metabolic Panel and Urinalysis (UA)	One each
Preventive Mammogram Services	One mammogram, including 3-D, is limited to 130% of the Medicare reimbursement amount; the maximum reimbursement amount applies only to Covered Services received inside the state of Ohio, as mandated by the state of Ohio.
Preventive Pap Tests and Associated Examinations (age 21 and over)	One test One examination
Preventive Physical Examinations (age 21 and over)	Two examinations

MAXIMUM LIFETIME BENEFIT PER COVERED PERSON	
Infertility Medical Treatment	$30,000

COINSURANCE AND COPAYMENTS FOR COVERED SERVICES		
TYPE OF SERVICE (Institutional and Professional)	**For Covered Services received from a Network Provider, you pay the following portion, based on the Allowed Amount**	**For Covered Services received from a Non-Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (1)**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
EMERGENCY ROOM SERVICES		
The Institutional Charge for use of the Emergency Room for an Emergency Medical Condition	10%	
Emergency Room Physician's Charges for an Emergency Medical Condition	10%	
All other related Charges for an Emergency Medical Condition	10%	
The Institutional Charge for use of the Emergency Room for **non-emergency** care	$250 Copayment, waived if admitted, then 10%, not subject to the Deductible	$250 Copayment, waived if admitted, then 20%, not subject to the Deductible
Emergency Room Physician's Charges in a **non-emergency**	10%	10%
All other related Charges in a **non-emergency**	Any applicable Deductible, Out-of-Pocket Maximum or Copayment corresponds to the type of service received.	Any applicable Deductible, Out-of-Pocket Maximum or Copayment corresponds to the type of service received.
HEARING SERVICES		
Hearing aids and Related Services for Covered Persons under age 22	0%, not subject to the Deductible	20%
INPATIENT SERVICES		
Maternity	10%	20%
Physical Medicine and Rehabilitation	10%	20%
Semi-Private Room and Board	10%	20%
Skilled Nursing Facility	10%	20%
MENTAL HEALTH CARE, DRUG ABUSE AND ALCOHOLISM SERVICES		
Mental Health Care, Drug Abuse and Alcoholism Services	Any applicable Deductible or Out-of-Pocket Maximum corresponds to the type of service received and is payable on the same basis as any other illness (e.g., emergency room visits for a Mental Illness will be paid according to the Emergency Services section above).	
OUTPATIENT REHABILITATIVE SERVICES		
Cardiac Rehabilitation Services	10%	20%
Chiropractic Services	10%	20%
Occupational Therapy Services	10%	20%
Physical Therapy Services	10%	20%
Pulmonary Therapy Services	10%	20%
Speech Therapy Services	10%	20%

COINSURANCE AND COPAYMENTS FOR COVERED SERVICES		
TYPE OF SERVICE (Institutional and Professional)	**For Covered Services received from a Network Provider, you pay the following portion, based on the Allowed Amount**	**For Covered Services received from a Non-Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (1)**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
PHYSICIAN/OFFICE SERVICES (includes Mental Health and Substance Abuse Disorders)		
Immunizations • herpes zoster (shingles) (age 19 and over) • human papillomavirus vaccine (HPV) • influenza (flu vaccine)	0%, not subject to the Deductible	20%
Immunizations (other than those covered under PPACA) • diphtheria toxoid • diphtheria/tetanus toxoids (DT) • hepatitis B • measles-mumps-rubella vaccine (MMR) • meningococcal vaccine • pneumococcal • pneumococcal polysaccharide • rabies vaccine • tetanus toxoid • varicella (chicken pox)	10%	20%
Medically Necessary Office Visits	10%	20%
Urgent Care Office Visits	10%	20%
PREVENTIVE AND WELLNESS SERVICES		
Preventive Services are provided in accordance with state and federal law. Please refer to the "Preventive and Wellness Services" health care benefit for details. (4)	0%, not subject to the Deductible	20%
Chest X-ray, Complete Blood Count (CBC), Comprehensive Metabolic Panel, Electrocardiogram (EKG) and Urinalysis	0%, not subject to the Deductible	20%
Prostate Specific Antigen (PSA) Tests	0%, not subject to the Deductible	20%
Colonoscopy and Sigmoidoscopy (age 45 and over)	0%, not subject to the Deductible	20%
SURGICAL SERVICES		
Inpatient Surgery	10%	20%
Outpatient Surgery	10%	20%

COINSURANCE AND COPAYMENTS FOR COVERED SERVICES		
TYPE OF SERVICE (Institutional and Professional)	**For Covered Services received from a Network Provider, you pay the following portion, based on the Allowed Amount**	**For Covered Services received from a Non-Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (1)**
IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.		
OTHER SERVICES		
Ambulance Services	20%	
All Other Covered Services	10%	20%

Comprehensive Major Medical Notes

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

Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, preventive immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

MAJOR MEDICAL HEALTH CARE BENEFIT BOOK

This Benefit Book describes the health care benefits available to you as a Covered Person in the Self-Funded Health Benefit Plan (the Plan) offered to you by your Employer through Stark County Schools Council of Governments (the Group). This is not a summary plan description by itself. However, it may be attached to or included with a document prepared by your Group that is called a summary plan description.

There is an Administrative Services Agreement between The Claims Administrator and the Group pursuant to which The Claims Administrator processes claims and performs certain other duties on behalf of the Group.

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

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

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

This Benefit Book is not a Medicare Supplement Benefit Book. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from The Claims Administrator.

HOW TO USE YOUR BENEFIT BOOK

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

The **Schedule of Benefits** gives you information about the limits and maximums of your coverage and explains your Coinsurance, Copayment and Deductible obligations, if applicable.

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

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

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

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

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

DEFINITIONS

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

Agreement - the administrative services agreement between The Claims Administrator and your Group. The Agreement includes the individual Enrollment Applications of the Cardholders, this Benefit Book, Schedules of Benefits and any Riders or addenda.

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

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

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

Benefit Book - this document.

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

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

Biosimilar Prescription Drug - a Prescription Drug that:

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

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

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

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

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

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

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

Contracting - the status of a Provider:

- that has an agreement with The Claims Administrator about payment for Covered Services; or
- that is designated by The Claims Administrator as Contracting.

Contracting Specialty Pharmacy - a Pharmacy which dispenses Specialty Prescription Drugs and which has a contractual obligation with The Claims Administrator to provide services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Enrollment Application - a form (paper or electronic) you complete for yourself and your Eligible Dependents to be considered for coverage under the Plan.

Essential Health Benefits - benefits defined under federal law (PPACA) as including benefits in at least the following categories; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Refer to the Schedule of Benefits and the Health Care Benefits section of this Benefit Book to identify which of these Essential Health Benefits are included in this plan.

Excess Charges - the difference between Billed Charges and the applicable Allowed Amount or Non-Contracting Amount. You may be responsible for Excess Charges when you receive services from a Non-Contracting Provider.

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

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

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

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

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

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

Group - the organization who enters into an Agreement with The Claims Administrator for The Claims Administrator to provide administrative services for such organization's health plan.

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

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

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

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

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

Immediate Family - the Cardholder and the Cardholder'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.

Independent Freestanding Emergency Department - a health care facility that:

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

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

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

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

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

Medically Necessary (or Medical Necessity) - a Covered Service, supply and/or Prescription Drug that is required to diagnose or treat a Condition and which The Claims Administrator 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 – all Conditions covered under the Plan, except for substance use disorders, that fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the International Classification of Diseases (ICD) manual or that are listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Newly added mental health Conditions added to the ICD or DSM will start to be covered no later than on the first day of the plan year on or after the date that is one year after the Condition is added to the ICD or DSM.

Negotiated Amount - the amount the Provider or Pharmacy has agreed with The Claims Administrator to accept as payment in full for Covered Services, subject to the limitations set forth below.

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

The Negotiated Amount for Providers does not include adjustments and/or settlement due to guaranteed discount corridor provisions, maximum charge increase limitation violations or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim at the time the claim is adjudicated or adjusted. In addition, the Negotiated Amount for Prescription Drugs does not include Pharmacy rebates or guaranteed discount settlements. The Claims Administrator receives the difference between the charges contracted with the Pharmacy Benefit Manager (PBM) and the Allowed Amount. This amount is sometimes referred to as spread pricing. The rebates, guaranteed discount settlements and spread pricing are all part of the Claim Administrator's reasonable compensation for providing PBM services to the Plan.

In certain circumstances, The Claims Administrator, through an affiliated company, may have an agreement or arrangement with a vendor which purchases the services, supplies or products from Providers instead of The Claims Administrator contracting directly with Providers themselves. The Claims Administrator's agreement or arrangement with that vendor may not reflect the vendor's purchase price from the Provider, but may be based on some other contractual arrangement, such as a guaranteed discount. In these circumstances, the Negotiated Amount will be based upon the price The Claims Administrator receives from the vendor and not upon the vendor's actual purchase price from the Provider. Vendors include, but are not limited to, durable medical equipment providers, other managed care providers, home health providers and other provider networks.

Network - a limited panel of Providers as designated by The Claims Administrator known as a preferred provider organization.

Network Provider - a Provider that is included in a limited panel of Providers as designated by The Claims Administrator and for which the greatest benefit will be payable when one of these Providers is used.

Non-Contracting - the status of a Provider that does not have a contract with The Claims Administrator or one of its networks.

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

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

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

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

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

- **Alcoholism Treatment Facility -** a facility that mainly provides detoxification and/or rehabilitation treatment for Alcoholism.
- **Ambulatory Surgical Facility -** a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a Physician and also includes nursing services.
- **Day/Night Psychiatric Facility -** a facility that is primarily engaged in providing diagnostic services and therapeutic services for the Outpatient treatment of Mental Illness. These services are provided through either a day or night treatment program.
- **Dialysis Facility -** a facility that mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- **Drug Abuse Treatment Facility -** a facility that mainly provides detoxification and/or rehabilitation treatment for Drug Abuse.
- **Home Health Care Agency -** a facility that meets the specifications set forth in the applicable state law and that provides nursing and other services as specified in the Home Health Care Services section of this Benefit Book. A Home Health Care Agency is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Hospice Facility -** a facility that provides supportive care for patients with a reduced life expectancy due to advanced illness as specified in the Hospice Services section of this Benefit Book.
- **Psychiatric Facility -** a facility that is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.

- **Psychiatric Hospital -** a facility that is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Inpatient basis. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must be provided under the supervision of a registered nurse.
- **Skilled Nursing Facility -** a facility that primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a Physician.

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

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

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

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

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

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

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

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

PPACA - Patient Protection and Affordable Care Act

Preauthorization - A decision by The Claims Administrator that a health care service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. This is also referred to as "precertification" or "prior approval". The Claims Administrator requires Preauthorization before you are admitted as an Inpatient in a Hospital or before you receive certain services, except for an Emergency Medical Condition. Certain Network Providers who meet specified criteria for frequently approved services may receive an automatic approval for those services. Payment of benefits is still subject to all other terms and conditions of the Plan.

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

Professional - a Physician or Other Professional Provider.

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

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

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

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

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

Rider - a document that amends or supplements your coverage.

Screening Mammography - a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening Mammography" includes digital breast tomosynthesis. "Screening mammography" includes two views for each breast. The term also includes the Professional interpretation of the film. "Screening mammography" does not include diagnostic mammography.

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

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

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

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

Specialty Prescription Drugs - Prescription Drugs that:

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

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

Substance Abuse - Alcoholism and/or Drug Abuse.

Supplemental Breast Cancer Screening - any additional screening method deemed medically necessary by a treating health care Provider for proper breast cancer screening in accordance with applicable American college of radiology guidelines, including magnetic resonance imaging, ultrasound, or molecular breast imaging.

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 The Claims Administrator.

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

- the patient receiving the services;
- another health care Professional with whom the Provider of the services is consulting regarding the patient.

The Claims Administrator – The selected carrier assigned to administer your benefits, i.e.: AultCare, CVS/Caremark and/or Medical Mutual.

Transplant Center - a facility approved by The Claims Administrator that is an integral part of a Hospital and that:

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

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

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

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

ELIGIBILITY

Enrolling for Coverage

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

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

Eligible Employees

An Eligible Employee is:

An employee of the Group who meets the eligibility requirements of the Group including working the required number of hours that the Group requires for eligibility. Any applicable waiting period must be satisfied but will not exceed 90 days.

No person who is eligible to enroll will be denied enrollment based upon health status, health care needs, genetic information, previous medical information, disability or age.

Eligible Dependents

An Eligible Dependent is:

- the Cardholder's spouse:
  - provided you are not legally separated
  - who meets the terms of the Group’s working spouse rule;
- the Cardholder's or spouse's:
  - natural children;
  - children placed for adoption and legally adopted children;
  - children for whom either the Cardholder or Cardholder's spouse is the Legal Guardian or Custodian; or
  - any children who, by court order, must be provided health care coverage by the Cardholder or Cardholder's spouse.
- the Cardholder's stepchildren, provided the natural parent remains married to the Cardholder and resides in the household.

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

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

Child Support Order

In general, a medical child support order is a court order that requires an Eligible Employee to provide medical coverage for his or her children in situations involving divorce, legal separation or paternity dispute. A medical child support order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. This Plan provides benefits according to the requirements of a medical child support order that is entered by a court of competent jurisdiction or by a local child support enforcement agency. The Group will promptly notify affected Cardholders if a medical child support order is received. Once the dependent child is enrolled under a medical child support order, the child's appointed guardian will receive a copy of all pertinent information provided to the Eligible Employee. In addition, should the Eligible Employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

Effective Date

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

Changes in Coverage

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 employer's benefit administrator who must then notify The Claims Administrator of the change.

Coverage for a spouse and other Eligible Dependents who become eligible by reason of marriage will be effective on the date of the marriage if a request for their coverage is submitted to the Group within 31 days of marriage.

A newborn child or an adopted child will be covered as of the date of birth or adoptive placement, provided that you request enrollment within 31 days of the date of birth or adoptive placement. Coverage will continue for an adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

It is important to complete and submit your Enrollment application promptly, because the date this new coverage begins will depend on when you request enrollment.

There are occasions when circumstances change and only the Cardholder is eligible for coverage. Family coverage must then be changed to individual coverage. In addition, The Claims Administrator must be notified when you or an Eligible Dependent becomes eligible for Medicare.

Special Enrollment

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

1. In order to qualify for special enrollment rights because of loss of coverage, you or your Eligible Dependent must have had other group health plan coverage at the time coverage under this plan was previously offered.
2. If coverage was non-COBRA, eligibility for special enrollment includes:
    a. Employer's contributions end
    b. Legal separation or divorce
    c. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan)
    d. Death of an Eligible Employee
    e. Termination of employment
    f. Reduction in the number of hours of employment that results in a loss of eligibility for plan participation (including a strike, layoff or lock-out)
    g. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual
    h. Termination of an employee's or dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)
    i. The employee or dependent is determined to be eligible for premium assistance in the Group's plan under a Medicaid or CHIP plan.
3. If you or your Eligible Dependent has COBRA coverage, the coverage must be exhausted in order to trigger a special enrollment right. Generally, this means the entire 18, 29 or 36-month COBRA period must be completed in order to trigger a special enrollment for loss of other coverage.
4. Enrollment must be supported by written documentation of the termination of the other coverage with the effective date of said termination stated therein. With the exception of items "h" (termination of Medicaid or CHIP coverage) and "i" (eligibility for premium assistance) above, notice of intent to enroll must be provided to The Claims Administrator by the employer no later than thirty-one (31) days following the triggering event with coverage to become effective on the date the other coverage terminated. For items "h" and "i" above, notice of intent to enroll must be provided to The Claims Administrator by the employer within sixty (60) days following the triggering event, with coverage to become effective on the date of the qualifying event.

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

Your Identification Card

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

Your identification card is the property of The Claims Administrator 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 "Prior Approval of Benefits Received from Non-Network or Non-Contracting Providers" in the "How Claims Are Paid" section of the General Provisions for information regarding services received from Providers who are not in the Network.

ALCOHOLISM AND DRUG ABUSE SERVICES

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

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

Inpatient admissions to a Hospital Provider or Residential Treatment Facility must be preauthorized. The telephone number for Preauthorization is listed on the back of your identification card. Contracting Providers and Network Providers will assure that Preauthorization is done; since the Provider is responsible for obtaining Preauthorization, there is no penalty to you if this is not done. If a Non-Contracting Provider is utilized, **you** are responsible for obtaining Preauthorization, failure to obtain prior authorization may result in a penalty as listed in the Schedule of Benefits. If you do not obtain Preauthorization, 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.

Excluded from coverage are Conditions that do not fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the International Classification of Diseases (ICD) manual or that are listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Newly added mental health Conditions added to the ICD or DSM will start to be covered no later than the first day of the plan year on or after the date that is one year after the Condition is added to the ICD or DSM.

ALLERGY TESTS AND TREATMENTS

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

AMBULANCE SERVICES

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

Covered transportation:

- from the scene of an accident or Emergency Medical Condition to the closest Hospital to provide Emergency Services;
- from one Hospital to another Hospital, including when we require a Covered Person to move from a Non-Network Hospital to a Network Hospital;

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

It is important to note:

- Ambulance services are a Covered Service only when the Covered Person's Condition is such that use of any other method of transportation could endanger the Covered Person's health.
- Covered Services include treatment of a sickness or injury by medical Professionals from an ambulance service when you are not transported, if Medically Necessary.
- Transportation for Emergency Medical Conditions will also be covered when provided by a professional ambulance service for other than local ground transportation, such as air and water transportation, only when special treatment is required and the transportation is to the nearest Hospital qualified to provide the special treatment.
- Transportation for Conditions other than Emergency Medical Conditions via ambulance are a Covered Service only when Medically Necessary and certified by a Physician, except:
  - when a Covered Person is required by The Claims Administrator to move from a Non-Network Provider to a Network Provider; or
  - when ordered by an employer, school, fire or public safety official, and the Covered Person is not in a position to refuse.

Non-Covered services for ambulance include, but are not limited to, trips to a Physician's office, clinic, a morgue or a funeral home. Transportation services provided by an ambulette or a wheelchair van are also not Covered Services.

AUTISM SPECTRUM DISORDERS

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

Covered Services include:

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

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

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

CASE MANAGEMENT

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

Coverage for these services must be approved in advance and in writing by The Claims Administrator.

To learn more about these services, you may contact The Claims Administrator's case management staff.

CLINICAL TRIAL PROGRAMS

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

In order to be eligible for benefits, the Covered Person must meet the following conditions (number 2 below is not required for cancer clinical trials in Ohio):

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

If the clinical trial is not available from a Network Provider, the Covered Person may participate in an Approved Clinical Trial administered by a Non-Contracting Provider. However, the Routine Patient Costs will be covered at the Non-Contracting Amount, and the Covered Person may be subject to balance billing up to the Provider's Billed Charges for the services.

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

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

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

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

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

No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the Approved Clinical Trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with travel to or from a facility providing the Approved Clinical Trial;
- An item or drug provided by the Approved Clinical Trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by an entity other than The Claims Administrator, including the sponsor of the Approved Clinical Trial;
- A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

DENTAL SERVICES FOR AN ACCIDENTAL INJURY OR MEDICAL NECESSITY

Dental services including anesthesia services and facility fees will only be covered for initial injuries sustained in an accident or in situations of medical necessity.

The accidental injury must have caused damage to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an accidental injury.

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

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

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

DIAGNOSTIC SERVICES

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

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

DRUGS AND BIOLOGICALS

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

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

Specialty Prescription Drugs require prior approval from The Claims Administrator.

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

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

Step Therapy: a program to determine whether you qualify for coverage based upon certain information, such as medical history, drug history, age and gender. This program requires that you try another drug before the target drug will be covered under this plan, unless special circumstances exist. If your Physician believes that special circumstances exist and would like to request a step therapy exemption, he or she may request a coverage review by providing The Claims Administrator with supporting documentation and rationale for the request. The Claims Administrator will approve or deny the request within forty-eight (48) hours for a request related to Urgent Care, or within ten (10) calendar days for all other requests. Your Provider may, on your behalf, appeal any exemption request that is denied. The Claims Administrator will approve or deny the appeal within forty-eight (48) hours for an appeal related to Urgent Care, or within ten (10) calendar days for all other requests. If the appeal does not resolve the disagreement, You, or Your authorized representative, may request an external review. Refer to the General Provision found later in this Policy entitled, "Filing an Internal Appeal and External Review" for more information. If The Claims Administrator does not approve or deny an exemption request or appeal, as applicable, within the time frames noted above, that exemption request is deemed to be approved. The Claims Administrator may still require that you try an alternative product that is deemed interchangeable by the FDA, before providing or renewing coverage for the Prescription Drug.

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

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

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

EMERGENCY SERVICES

You are covered for Medically Necessary Emergency Services for an Emergency Medical Condition. Emergency Services are available 24 hours a day, 7 days a week.

In the event of an emergency:

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

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

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

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

For **non-emergency** use of the Emergency Room and related charges, refer to your Schedule of Benefits.

HEARING AIDS FOR COVERED PERSONS UNDER AGE 22

For Covered Persons under age twenty-two (22) who are verified as being deaf or hearing impaired by a licensed audiologist, an otolaryngologist or other licensed Physician, benefits are provided for hearing aids and related services, subject to the limitations shown on the Schedule of Benefits.

For purposes of this coverage, the following definitions apply:

"Hearing aid" means any wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing, including all attachments, accessories, and arts thereof, except batteries and cords, that is dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter, or an otolaryngologist.

"Related Services" means services necessary to assess, select, and appropriately adjust or fit a hearing aid, to ensure optimal performance.

A Covered Person may choose a higher priced hearing aid and may pay the difference in cost above the benefit maximum appearing in the Schedule of Benefits, without any financial or contractual penalty to the Covered Person or to the Provider of the hearing aid.

Coverage is provided only for hearing aids that are considered medically appropriate to meet the needs of the Covered Person, according to professional standards established by the state speech and hearing professionals' board.

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;
- physical therapy, occupational therapy and speech therapy;
- medical and surgical supplies;
- non-self-administered drugs;
- oxygen and its administration;
- medical social services, such as the counseling of patients; and
- home health aide visits when you are also receiving covered nursing or therapy services.

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

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

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

HOSPICE SERVICES

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

The following Covered Services are considered hospice services:

- professional services of a registered or licensed practical nurse;
- physical therapy, occupational therapy and speech therapy;
- medical and surgical supplies;
- non-self-administered drugs;

- oxygen and its administration;
- medical social services, such as the counseling of patients;
- home health aide visits when you are also receiving covered nursing or therapy services;
- acute Inpatient hospice services;
- respite care;
- dietary guidance; counseling and training needed for a proper dietary program;
- durable medical equipment; and
- bereavement counseling for family members.

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

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

INFERTILITY SERVICES

Infertility Services include, but are not limited to:

- diagnostic testing and treatment necessary to diagnose infertility and to correct a physical or medical Condition causing infertility
- invitro fertilization
- artificial insemination
- gamete intrafallopian transfer (GIFT)
- zygote intrafallopian transfer (ZIFT)

See maximum lifetime benefit amount listed in the schedule of benefits.

INPATIENT HEALTH EDUCATION SERVICES

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

INPATIENT HOSPITAL SERVICES

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

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

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

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

- operating, delivery and treatment rooms and equipment;

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

Non-covered Hospital services include personal hygiene or convenience products.

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

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

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

Inpatient admissions to a Hospital must be preauthorized. The telephone number for Preauthorization is listed on the back of your identification card. Contracting Providers and Network Providers will ensure that Preauthorization is done; since the Provider is responsible for obtaining Preauthorization, there is no penalty to you if this is not done.

If a Non-Contracting Provider is utilized, **you** are responsible for obtaining Preauthorization, failure to obtain prior authorization may result in a penalty as listed in the Schedule of Benefits. If you do not obtain Preauthorization, 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 Transplant Services section.

INPATIENT PHYSICAL MEDICINE AND REHABILITATION SERVICES

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

MATERNITY SERVICES, INCLUDING NOTICE REQUIRED BY THE NEWBORNS' AND MOTHERS' PROTECTION ACT

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

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

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

- parent education;
- physical assessments of the mother and newborn;

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

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

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

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

Surrogacy: the Plan will cover Maternity Services as described in this Benefit Book for you if you are acting as a surrogate. However, to the extent that you receive any compensation or payment from any third party, even if the compensation or payment is designated for services other than medical expenses, The Claims Administrator has a right to subrogate against that compensation to the extent that it pays maternity claims under this Benefit Book. You are obligated to notify The Claims Administrator of any compensation or payment you receive as a result of acting as a surrogate and the benefits payable hereunder are contingent on your cooperation according to this provision. No coverage will be provided for maternity services Incurred by a person not covered under this Benefit Book who is acting as a surrogate for you or any Dependent.

MEDICAL CARE

Office Visits

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

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT

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

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

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

Items not covered include, but are not limited to:

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

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

Covered DME includes:

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

Deluxe

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

Repair/Warranty/Misuse

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

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

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

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

Items not covered include, but are not limited to:

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

Orthotic Devices - rigid or semi-rigid supportive devices used: 1) to support, align, prevent or correct deformities; 2) to improve the function of movable parts of the body; or 3) which limit or stop motion of a weak or diseased body part.These devices include, but are not limited to:

- cervical collars;
- ankle foot orthosis;
- corsets (back and surgical);
- splints (extremity);
- trusses and supports;
- slings;
- wristlets;
- built-up shoes; and
- custom-made shoe inserts.

Covered Services for orthotic devices are:

- The initial purchase, fitting and repair of the device.
- The cost of casting (if billed with the orthotic device and not separately), molding, fittings and adjustments.
- One replacement per year when Medically Necessary. Benefits may also be provided for Covered Persons under age 18, due to rapid growth, or for any Covered Person when an appliance is damaged and cannot be repaired.

Items not covered include, but are not limited to:

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

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

- replace all or part of a missing body organ or limb and its adjoining tissues; or

- replace all or part of the function of a permanently useless or malfunctioning body organ or limb.

Covered prosthetic appliances include:

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

Items not covered 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

Covered Services for the treatment of Mental Illness include:

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

Inpatient admissions to a Hospital Provider or Residential Treatment Facility Provider must be preauthorized. The telephone number for Preauthorization is listed on the back of your identification card. Contracting Providers and Network Providers will ensure that Preauthorization is done; since the Provider is responsible for obtaining Preauthorization, there is no penalty to you if this is not done. If a Non-Contracting Provider is utilized, **you** are responsible for obtaining Preauthorization, failure to obtain prior authorization may result in a penalty as listed in the Schedule of Benefits. If you do not obtain Preauthorization, 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.

Excluded from coverage are Conditions that do not fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the International Classification of Diseases (ICD) manual or that are listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Newly added mental health Conditions added to the ICD or DSM will start to be covered no later than the first day of the plan year on or after the date that is one year after the Condition is added to the ICD or DSM.

ORGAN TRANSPLANT SERVICES

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

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

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

Organ Transplant Preauthorization - In order for an organ transplant to be a Covered Service, the proposed course of treatment and the Inpatient stay for the organ transplant must both be preauthorized by The Claims Administrator.

Contracting Providers and Network Providers are responsible for obtaining Preauthorization of both the proposed course of treatment and the Inpatient stay. If a Non-Contracting Provider is utilized, the Covered Person is responsible for obtaining Preauthorization for both the proposed course of treatment and for the Inpatient stay. If the required Preauthorization does not occur, and the organ transplant is determined to be Experimental/Investigational or not to be Medically Necessary, the Covered Person may be responsible for all Billed Charges for that organ transplant.

After your Physician has examined you, he must provide The Claims Administrator with:

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

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

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

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

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

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

OTHER INPATIENT SERVICES

Based on State and/or Federal Law, the Plan will cover Medically Necessary services for gender affirming Surgery, subject to accepted medical clinical guidelines and The Claims Administrator's corporate medical policies.

OTHER OUTPATIENT SERVICES

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

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

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

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

OUTPATIENT INSTITUTIONAL SERVICES

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

Covered Institutional services include, but are not limited to:

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

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

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

OUTPATIENT REHABILITATIVE SERVICES

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

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

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

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

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

All occupational therapy services must be performed by a certified, licensed occupational therapist.

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

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

All physical therapy services must be performed by a certified, licensed physical therapist.

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

PREVENTIVE AND WELLNESS SERVICES

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

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

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

  Examples of preventive services covered by The Plan:

  - Health Education Services
    - Behavioral Counseling to Promote a Healthy Diet - Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases.
  - Gynecological Services
    - Screening Mammography for adult women
    - Supplemental Breast Cancer Screening for adult women who meet either of the following conditions:
      - The woman’s Screening Mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman has dense breast tissue;
      - The woman is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the woman’s health care Provider.

      The total benefit for a Screening Mammography or Supplemental Breast Cancer Screening under this plan, regardless of the number of claims submitted by Providers, will not exceed one hundred thirty percent (130%) of the Medicare reimbursement rate in Ohio for a Screening Mammography or Supplemental Breast Cancer Screening. If a Provider, Hospital, or other health care facility provides a service that is a component of the Screening Mammography or Supplemental Breast Cancer Screening and submits a separate claim for that component, a separate payment shall be made to the Provider, Hospital or other health care facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. The benefit paid for Screening Mammography and Supplemental Breast Cancer Screening constitutes full payment under this Benefit Book. No Provider, Hospital, or other health care facility shall seek or receive compensation in excess of the payment made that corresponds to the ratio paid by Medicare in Ohio, except for approved Deductibles, Copayments or Coinsurance.
  - PAP tests and associated examinations.
  - Physical Examinations
  - Screenings
    - blood glucose screenings and screenings for type 2 diabetes
    - bone density screenings
    - chlamydia screenings, limited to pregnant and sexually active women
    - cholesterol screenings

- colorectal cancer screenings: using fecal occult blood testing, sigmoidoscopy or colonoscopy
- hepatitis B virus screenings; limited to pregnant women in their first prenatal visit.

- Smoking cessation services
- Well childcare services
- Women's preventive services
  - These services include but are not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; Contraceptives and counseling for Contraceptives for women with reproductive capacity; sterilization procedures; breastfeeding; and domestic violence.

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

Other covered services that **may** be subject to a Deductible or Coinsurance are:

Diabetic self-management training and education services - when provided under the supervision of a licensed health care professional with expertise in diabetes. These services help to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diet and medical nutrition therapy.

Prostate Specific Antigen Tests - Prostate Specific Antigen (PSA) tests are covered.

Testing

- Bone Density
- Chest x-ray
- Complete Blood Count (CBC)
- Comprehensive Metabolic Panel
- Electrocardiogram (EKG)
- Urinalysis (UA)
- Colonoscopy
- Sigmoidoscopy

PRIVATE DUTY NURSING SERVICES

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

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

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

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

SKILLED NURSING FACILITY SERVICES

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

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 The Claims Administrator; and
- for Custodial Care, rest care or care which is only for someone's convenience.

SURGICAL SERVICES

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

- sterilization;
- therapeutic abortions;
- removal of bony impacted teeth;
- maxillary or mandibular frenectomy;
- diagnostic endoscopic procedures, such as colonoscopy and sigmoidoscopy;
- reconstructive Surgery following a mastectomy, including coverage for reconstructive Surgery performed on a non-diseased breast to establish symmetry as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedema;
- Surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes as determined by The Claims Administrator. 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.

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. The Claims Administrator will follow appropriate clinical editing guidelines.

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

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

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

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

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

TEMPOROMANDIBULAR JOINT SYNDROME SERVICES

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

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

URGENT CARE SERVICES

Health problems that require immediate attention which are not Emergency Medical Conditions are considered to be Urgent Care needs.

Examples of Urgent Care are:

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

WOMEN'S HEALTH SERVICES

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

EXCLUSIONS

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

1. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
2. Not performed within the scope of the Provider's license.
3. Not Medically Necessary or do not meet The Claims Administrator's policy, clinical coverage guidelines, or benefit policy guidelines.
4. Received from other than a Provider.
5. For Experimental or Investigational drugs, devices, medical treatments or procedures, unless otherwise specified.
6. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by The Claims Administrator.
7. For a Condition that occurs as a result of any act of war, declared or undeclared.
8. For a Condition resulting from direct participation in a riot, civil disobedience, nuclear explosion or nuclear accident.
9. For which you have no legal obligation to pay in the absence of this or like coverage.
10. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
11. Received from a member of your Immediate Family.
12. Incurred after you stop being a Covered Person unless otherwise specified in the Benefits After Termination of Coverage section.
13. For the following:
    - physical examinations or services required by an insurance company to obtain insurance;
    - physical examinations or services required by a governmental agency such as the FAA and DOT;
    - physical examinations or services required by an employer in order to begin or to continue working.
14. For radiologic imaging with no preserved film image or digital record.
15. For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability or similar laws, even when the Covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.
16. Received in a military facility for a military service-related Condition.
17. For court-ordered testing or care unless Medically Necessary.
18. For Surgery, associated anesthesia and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss or weight loss Surgery), unless otherwise specified.
19. For weight loss Surgery and any repairs, revisions or modifications of such Surgery, including weight loss device removal.
20. For Surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment.
21. For the removal of tattoos.
22. For dietary and/or nutritional counseling or training, unless otherwise specified or required by PPACA.
23. For educational services, including special education and remedial education, vocational services, recreational services, other non-clinical services, or services provided for training purposes, except as may be required by PPACA.
24. For endoscopic screening procedures, other than colonoscopies and sigmoidoscopies required by PPACA
25. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss or obesity.
26. For nutritional supplements taken orally.
27. For male Contraceptives and over-the-counter birth control without a prescription.
28. For reverse sterilization.
29. For devices, equipment and supplies used for the treatment of sexual dysfunction that is cosmetic in nature.

30. For elective abortions.
31. For treatment associated with teeth, dental X-rays, dentistry or any other dental processes, including treatment with intraoral prosthetic devices or any other method to alter vertical dimension of occlusion, or orthognathic (jaw) Surgery. This exclusion does not apply to treatment of temporomandibular joint (TMJ) disorders.
32. For dental implants, considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic, except as described in the "Dental Services for an Accidental Injury" benefit.
33. For personal hygiene and convenience items.
34. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except as described in the section entitled "Prosthetic Appliances" under the "Medical Supplies and Durable Medical Equipment" benefit.
35. For any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).
36. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
37. For lost, stolen, or damaged medical supplies or durable medical equipment.
38. For massotherapy or massage therapy, except as directly performed by a licensed physical therapist, occupational therapist or chiropractor.
39. For hypnosis and acupuncture.
40. For biofeedback, unless determined by The Claims Administrator to be a Covered Service in accordance with The Claims Administrator 's corporate medical policy.
41. For blood which is available without charge. For Outpatient blood storage services.
42. For Prescription Drugs, except as specified.
43. For preventive services, unless otherwise specified and in accordance with state and federal law.
44. For specialized camps.
45. For wilderness therapy, therapeutic living communities (including therapeutic farms), adventure-based therapy or similar programs.
46. For water aerobics.
47. For After Hours Care.
48. For missed appointments, completion of claim forms or copies of medical records.
49. For an interpretation charge by a pathologist when the interpretation or result is already automatically provided by a machine-read or automated laboratory test.
50. For stand-by charges of a Physician.
51. For any Charges not documented in Provider records.
52. For fraudulent or misrepresented claims.
53. For charges for doing research with Providers not directly responsible for your care.
54. For services as the result of an injury or illness caused by or contributed to by engaging in an assault or felony.
55. For a particular health service in the event that a Provider waives Copayments, Coinsurance (and/or the Deductible per Benefit Period); in such event, no benefits are provided for the health service for which the Copayments, Coinsurance (and/or the Deductible per Benefit Period) are waived.
56. For services billed by a Non-Contracting Provider that would not be covered if billed by a Contracting Provider, due to medical policy or other care management provisions, and for which the Contracting Provider would hold the patient harmless. If a Non-Contracting Provider bills the Covered Person for such services, the Covered Person is responsible for the cost of those services and must pay that Provider.
57. For non-Covered Services or services specifically excluded in the text of this Benefit Book.

GENERAL PROVISIONS

How to Apply for Benefits

Notice of Claim; Claim Forms

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

If you fail to receive a claim form within 15 days after you notify The Claims Administrator, you may send The Claims Administrator your bill or a written statement of the nature and extent of your loss; this must have all the information which The Claims Administrator 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 The Claims Administrator for processing with sufficient documentation to determine whether Covered Services have been provided to you. The Claims Administrator must receive a completed claim with the correct information. The Claims Administrator may require nurses' or Providers' notes or other medical records before proof of loss is considered sufficient to determine benefit coverage.

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

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

How Claims are Paid

You have a choice when selecting a Provider. This plan provides coverage for Network Providers, other Contracting Providers and Non-Contracting Providers. However, the type of Provider you choose to utilize can have a large impact on your out-of-pocket expenses. For Covered Services, The Claims Administrator will calculate its payment based upon the applicable Allowed Amount or Non-Contracting Amount. Please review the following descriptions for additional information.

No Surprise Billing

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

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

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

There may be occasions where you knowingly and purposefully seek care from a Non-Network or Non-Contracting Provider and voluntarily give consent for services for which you can be balance billed. For example, if you have a complex health Condition and want to be treated by a Specialist who is not in this Plan's Network, and that Specialist will not treat you unless he or she can bill you directly, including any balance billing. Before you can consent to be balance billed, your Non-Network or Non-Contracting Provider must give you, or your authorized representative, a written notice, in advance of performing the service, that includes detailed information designed to ensure that you knowingly accept out-of-pocket charges. The notice must also include an estimate of the Provider's charge for the services. **If you voluntarily give written consent after receiving the notice, your Copayments, Deductibles and Coinsurance will be based upon the Non-Network level of benefits shown in the Schedule of Benefits, and you will also be responsible for any balance billing for the services received.**

Network and other Contracting Providers

The Claims Administrator has agreements with Providers both inside and outside the Network, both of which are referred to as Contracting Providers. While the highest level of benefits is provided when you obtain Covered Services from Network Providers, both Network Providers and other Contracting Providers have agreed not to bill for any amount of Covered Charges above the Allowed Amount, except for services and supplies for which The Claims Administrator has no financial responsibility due to a benefit maximum. The Allowed Amount is the lesser of the applicable Negotiated Amount or the Covered Charge. Refer to the Schedules of Benefits to determine the amount of Copayments, Deductibles and Coinsurance that apply when utilizing Network Providers versus other Contracting Providers and Non-Contracting Providers.

Continuity of Care when a Provider's Contract with The Claims Administrator Ends

If a Provider's contract with The Claims Administrator ends:

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

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

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

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

Serious and Complex Condition means:

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

Non-Contracting Providers

If you choose to obtain services from a Non-Network or Non-Contracting Provider, your out-of-pocket expenses will likely be significantly higher than what you would pay by choosing a Network Provider. Copayments, Deductibles and Coinsurance are usually higher when utilizing a Non-Network or Non-Contracting Provider, as shown on the Schedules of Benefits. Also, The Claims Administrator calculates its payments to Non-Contracting Providers based upon the Non-Contracting Amount. This means that in addition to your increased out-of-pocket expenses described above, you may also be responsible for Excess Charges, up to the amount of the Provider's Billed Charges. This is sometimes referred to as "balance billing." Excess Charges billed by Non-Contracting Providers DO NOT apply to the Out-of-Pocket Maximum, except as stated in the "No Surprise Billing" section of this Benefit Book.

As noted in the General Exclusions, a Non-Network or Non-Contracting Provider may bill you for certain services that would not be covered under this Plan if they were obtained from a Contracting Provider. While not necessarily shown as an exclusion in this Benefit Book, if a Non-Contracting Provider bills for these services, they are not covered under this Plan and are the Covered Person's responsibility (except for Emergency Services). An example would be a bill from a pathologist to interpret a machine-run lab test; a Contracting Provider would not bill one of its patients or The Claims Administrator for this service and, therefore, it would not be covered if billed by a Non-Contracting Provider.

If you obtain covered Emergency Services from a Non-Contracting Provider, The Claims Administrator pays for benefits in an amount equal to the greatest of the following:

1. The applicable Negotiated Amount. If more than one amount is negotiated with Contracting Providers for the Emergency Service, the amount payable is the median of these amounts.
2. The Non-Contracting Amount.
3. The amount that would be paid under Medicare for the Emergency Service.

Your Financial Responsibilities

You are responsible for:

- Any Copayment, Deductible and Coinsurance amounts specified in the Schedule of Benefits. Copayments are generally required to be paid at the time of service. Some Providers can determine the amount due for your Deductible and Coinsurance from The Claims Administrator and may require payment from you before providing their services.
- Non-Covered Charges.
- Billed Charges for all services and supplies after benefit maximums have been reached.
- Excess Charges for services and supplies rendered by Non-Network and Non-Contracting Providers, except as stated in the "No Surprise Billing" section of this Benefit Book.
- Billed Charges for services that are not Medically Necessary.
- Incidental charges.

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

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

Benefit Period Deductible

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

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

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

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

Coinsurance

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

Copayments

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

Out-of-Pocket Maximum

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

Schedule of Benefits

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

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

Provider Status and Direction of Payment

The Claims Administrator has agreed to make payment directly to Network and Contracting Providers for Covered Services.

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

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

The Claims Administrator 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. The Claims Administrator has and retains the sole right to designate Providers as Contracting and/or Network.

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

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

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

Prior Approval of Benefits received from Non-Network or Non-Contracting Providers

In some cases, The Claims Administrator may determine that certain Covered Services can only be provided by a Non-Network or Non-Contracting Provider. If Covered Services provided by a Non-Network or Non-Contracting Provider are approved in advance by The Claims Administrator, benefits will be provided as if the Covered Services were provided by a Network Provider. However, except as stated in the "No Surprise Billing" section of this Benefit Book, Non-Contracting Providers may not accept our Allowed Amount as payment in full, and you may have to pay the Excess Charges.

To obtain prior approval of treatment by a Non-Network or Non-Contracting Provider, your Network Provider must provide The Claims Administrator with:

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

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

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

Preauthorization

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

Examples of Outpatient services that may require Preauthorization are:

- Durable medical equipment and devices

- MRIs and PET scans
- Therapy
- Home health care
- Private duty nursing

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

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

Contracting and Network Providers will assure that Preauthorization is obtained for you. However, if you utilize a Non-Contracting Provider, the Hospital or your Provider should contact The Claims Administrator before you receive the service to ensure that your procedure/service is Medically Necessary. If the Hospital or your Provider does not obtain Preauthorization for you, you must obtain Preauthorization by calling The Claims Administrator telephone number on your identification card at least two days prior to receiving the Outpatient service or to your admission to the Hospital.

If Preauthorization to utilize a Non-Contracting Provider is not obtained for the Inpatient admission or Outpatient service, and that admission or service is determined to not be Medically Necessary, you will be responsible for all Billed Charges for that service, whether Inpatient or Outpatient.

Preauthorization is not required in the event of an Emergency Admission. However, the Hospital, the Covered Person, or his or her family member or representative must notify The Claims Administrator within 48 hours or two working days of admission, or as soon as reasonably possible.

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

Explanation of Benefits

After The Claims Administrator 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 claim details and a telephone number if you have any questions.

Time of Payment of Claims

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

Foreign Travel

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

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

Circumstances Beyond the Control of the Plan

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

Filing a Complaint

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, the Cardholder 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, The Claims Administrator Customer Service representative will review the claim for correctness in processing. If the claim was processed according to terms of the Plan, the Customer Service representative will telephone the Cardholder with the response. If attempts to telephone the Cardholder are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the Cardholder will receive a check, Explanation of Benefits or letter explaining the revised decision.

Quality of Care issues are addressed by The Claims Administrator.

If you are not satisfied with the results, and your complaint is regarding an Adverse Benefit Determination, you may continue to pursue the matter through the appeal process.

Additionally, the Customer Service Representative will notify you of how to file an appeal.

Benefit Determination for Claims (Internal Claims Procedure)

Claims Involving Urgent Care

A **Claim involving Urgent Care** is a claim for Medical Care or treatment with respect to which the application of the timeframes for making non-Urgent Care determinations (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (b) in the opinion of a Physician with knowledge of the claimant's medical Condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. With respect to prior authorization requests submitted by health care practitioners (as defined in Ohio Revised Code 3923.041(A)) through The Claims Administrator's electronic software system only, a Claim Involving Urgent Care also means a claim for Medical Care or other service for a Condition where the application of the timeframes for making non-urgent care determinations (a) could seriously jeopardize the life, health, or safety of the claimant or others due to the claimant's psychological state; or (b) in the opinion of a practitioner with knowledge of the claimant's medical or behavioral condition, would subject the claimant to adverse health consequences without the care or treatment that is the subject of the request.

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

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

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

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

If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a Claim involving Urgent Care through The Claims Administrator 's electronic software system, The Claims Administrator will respond to the request within 48 hours of receipt and indicate whether the request is denied, approved, or if additional information is needed to process the request.

If additional information is needed to process the request, The Claims Administrator will notify the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) within 24 hours of receipt of the Claim involving Urgent Care and the health care practitioner will have 48 hours to respond. Because we are required to make a decision within 48 hours after receipt of the Claim involving Urgent Care, your claim may still be denied when we request additional information.

Concurrent Care Claims

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

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

Pre-Service Claims

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

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

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

If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a Pre-Service Claim through The Claims Administrator's electronic software system, The Claims Administrator will respond to the request within 10 days of receipt and indicate whether the request is denied, approved, or if additional information is needed to process the request. If additional information is needed to process the request, the health care practitioner will then have 45 days to respond with the additional information. If your health care practitioner does not provide the information, your claim may be denied.

For only those prior authorization requests that are submitted by a health care practitioner (as defined in Ohio Revised Code 3923.041(A)) through The Claims Administrator's electronic software system that are approved by The Claims Administrator, except in cases of fraudulent or materially incorrect information, The Claims Administrator will not retroactively deny a prior authorization for a health care service, drug, or device when all of the following are met: (1) the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a prior authorization request to The Claims Administrator for a health care service, drug, or device; (2) The Claims Administrator approves the prior authorization request after determining that all of the following are true: (a) the claimant is eligible under the health benefit plan; (b) the health care service, drug, or device is covered under the claimant's health benefit plan; and (c) the health care service, drug, or device meets The Claims Administrator's standards for medical necessity and prior authorization; (3) the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) renders the health care service, drug, or device pursuant to the approved prior authorization request and all of the terms and conditions of the health care practitioner's contract with The Claims Administrator; (4) on the date the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) renders the prior approved health care service, drug, or device, all of the following are true: (a) the claimant is eligible under the health benefit plan; (b) the claimant's condition or circumstances related to the claimant's care has not changed; (c) the health care practitioner submits an accurate claim that matches the information submitted by the health care practitioner in the approved prior authorization request; and (5) if the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a claim that includes an unintentional error and the error results in a claim that does not match the information originally submitted by the health care practitioner in the approved prior authorization request, upon receiving a denial of services from The Claims Administrator, the health care practitioner may resubmit the claim with the information that matches the information included in the approved prior authorization.

Post-Service Claims

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

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

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

If you file a Post-Service Claim for a service where prior authorization was required but not obtained, upon written request, The Claims Administrator shall permit a retrospective review if the service in question meets all of the following: (i) the service is directly related to another service for which the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submitted a prior authorization request through The Claims Administrator's electronic software system, prior approval has already been obtained from The Claims Administrator on such request, and the original prior authorized service has already been performed; (ii) the new service was not known to be needed at the time the original prior authorized service was performed; and (iii) the need for the new service was revealed at the time the original authorized service was performed. Once the written request and all necessary information is received, The Claims Administrator will review the claim for coverage and medical necessity. The Claims Administrator will not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question.

Adverse Benefit Determination Notices

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

- information sufficient to identify the claim or health care service involved, including the health care provider, the date of service, and claim amount, if applicable;
- the specific reason(s) for the Adverse Benefit Determination;
- reference to the specific plan provision(s) on which the Adverse Benefit Determination is based;

- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of The Claims Administrator's appeal procedures and applicable timeframes, including the expedited appeal process, if applicable;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the Adverse Benefit Determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the Adverse Benefit Determination was based on Medical Necessity, Experimental Treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

Filing an Internal Appeal and External Review

I. Definitions

For the purposes of this "Filing an Internal Appeal and External Review" Section, the following terms are defined as follows:

Adverse Benefit Determination - a decision by a Health Plan Issuer:

- To deny, reduce, or terminate a requested Health Care Service or payment in whole or in part, including all of the following:
  - a determination that the Health Care Service does not meet the Health Plan Issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;
  - a determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
  - a determination that a Health Care Service is not a Covered Service;
  - the imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To rescind coverage on a Health Benefit Plan.

Authorized Representative - an individual who represents a Covered Person in an internal appeal process or external review process, who is any of the following: (1) a person to whom a Covered Person has given express written consent to represent that person in an internal appeal process or external review process; (2) a person authorized by law to provide substituted consent for a Covered Person; or (3) a family member or a treating health care professional, but only when the Covered Person is unable to provide consent.

Covered Service - please refer to the definition of this term in the Definitions Section in this Benefit Book.

Covered Person - please refer to the definition of this term in the Definitions Section in this Benefit Book.

Emergency Medical Condition - please refer to the definition of this term in the Definitions Section in this Benefit Book.

Emergency Services - please refer to the definition of this term in the Definitions Section in this Benefit Book.

Final Adverse Benefit Determination - an Adverse Benefit Determination that is upheld at the completion of The Claims Administrator 's mandatory internal appeal process.

Health Benefit Plan - a policy, contract, certificate, or agreement offered by a Health Plan Issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services.

Health Care Services - services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Plan Issuer - an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Superintendent of Insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services under a Health Benefit Plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health Plan Issuer" includes a third-party administrator to the extent that the benefits that such an entity is contracted to administer under a Health Benefit Plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the Superintendent.

Independent Review Organization - an entity that is accredited to conduct independent external reviews of Adverse Benefit Determinations.

Rescission or to Rescind - a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Stabilize - please refer to the definition of this term in the Definitions Section in this Benefit Book.

Superintendent - the superintendent of insurance.

Utilization Review - a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

II. How to File an Appeal

If you are not satisfied with an Adverse Benefit Determination, you may file an appeal.

There is no fee to file an appeal. Appeals can be filed regardless of the claim amount at issue.

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

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

AultCare
Grievance and Appeals Department
P.O. Box 6029
Canton, Ohio 44706-0910
FAX: (330) 363-6360

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

III. Internal Appeals Procedure

A. Mandatory Internal Appeal Level

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

Mandatory internal appeals must be filed within 180 days from your receipt of a notice of Adverse Benefit Determination.

All requests for appeal may be made by submitting an appeal form, by calling Customer Service or in writing as described above in the How to File an Appeal section.

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law. 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 review of an appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination.

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

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

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

You will receive continued coverage pending the outcome of the appeals process. For this purpose, The Claims Administrator may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review. If The Claims Administrator's Adverse Benefit Determination is upheld, you may be responsible for the payment of services you receive while the appeals process was pending.

1. **Types of Mandatory Internal Appeals and Timeframes**

    a. **Appeal of Claim Involving Urgent Care**

    - You, your Authorized Representative or your Provider may request an appeal of a claim involving Urgent Care. The appeal does not need to be submitted in writing. You, your Authorized Representative, or your Physician should call the Care Management telephone number on your identification card as soon as possible. Appeals of claims involving Urgent Care typically involve those claims for Medical Care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations (1) could seriously jeopardize the life or health of a patient, or the ability of the patient to regain maximum functions, or (2) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The appeal must be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request to appeal. If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) uses The Claims Administrator s electronic software system to request an appeal of a Claim Involving Urgent Care, The Claims Administrator will respond to the appeal within 48 hours of receipt. The expedited appeal process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

    b. **Pre-Service Claim Appeal**

    - You or your Authorized Representative may request a pre-service claim appeal. Pre-service claim appeals are those requested when you have received a denial of a Pre-Service Claim in advance of you receiving Medical Care. The pre-service claim appeal must be requested within 180 days of the date you received notice of an Adverse Benefit Determination but before you have received the service. When The Claims Administrator receives a pre-service claim appeal in writing, it must be decided within a reasonable period

of time appropriate to the medical circumstances, but not later than 30 days after the receipt of the request. When The Claims Administrator receives a pre-service claim appeal from your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) when you have authorized him or her to appeal on your behalf and the health care practitioner uses The Claims Administrator's electronic software system for prior authorization, The Claims Administrator will respond to the appeal within 10 calendar days of receipt.

c. **Post Service Claim Appeal**

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

2. **Notices of Final Adverse Benefit Determination after Appeal:**

All notices of a Final Adverse Benefit Determination after an appeal will be culturally and linguistically appropriate and will include the following:

- Information sufficient to identify the claim or health care service involved, including the health care provider, the date of service, and claim amount, if applicable;
- the specific reason(s) for the Adverse Benefit Determination;
- reference to the specific plan provision(s) on which the Adverse Benefit Determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the Adverse Benefit Determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- if the Adverse Benefit Determination was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request;
- a discussion of the decision;
- a description of applicable appeal procedures; and
- disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance.

B. What Happens After the Mandatory Internal Appeal Level

If your claim is denied at the mandatory internal appeal level, you may be eligible for either the External Review Process by an Independent Review Organization for Adverse Benefit Determinations involving medical judgment or the External Review Process by the Ohio Department of Insurance for contractual issues that do not involve medical judgment.

IV. External Review Process

A. Contact Information for Filing an External Review

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

AultCare
Grievance and Appeals Department
P.O. Box 6029
Canton, Ohio 44706-9010
FAX: (330) 363-6360

B. Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code, all Health Plan Issuers must provide a process that allows a person covered under a Health Benefit Plan or a person applying for Health Benefit Plan coverage to request an independent external review of an Adverse Benefit Determination. This is a summary of that external review process. An Adverse Benefit Determination is a decision by The Claims Administrator to deny a requested Health Care Service or payment because services are not covered, are excluded, or limited under the plan, or the Covered Person is not eligible to receive the benefit.

The Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny Health Benefit Plan coverage or to Rescind coverage.

C. Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The Covered Person does not pay for the external review. There is no minimum cost of Health Care Services denied in order to qualify for an external review. However, the Covered Person must generally exhaust

The Claims Administrator's mandatory internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

1. **External Review by an IRO**

   A Covered Person is entitled to an external review by an IRO in the following instances:

   - The Adverse Benefit Determination involves a medical judgment or is based on any medical information.
   - The Adverse Benefit Determination indicates the requested service is Experimental or Investigational, the requested Health Care Service is not explicitly excluded in the Covered Person's Health Benefit Plan, and the treating physician certifies at least one of the following:
     - Standard Health Care Services have not been effective in improving the condition of the Covered Person;
     - Standard Health Care Services are not medically appropriate for the Covered Person;
     - No available standard Health Care Service covered by The Claims Administrator is more beneficial than the requested Health Care Service.

   There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

   - The Covered Person's treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal, and the Covered Person has filed a request for an expedited internal appeal.
   - The Covered Person's treating physician certifies that the Final Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
   - The Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or Health Care Service for which the Covered Person received Emergency Services, but has not yet been discharged from a facility.
   - An expedited internal appeal is already in progress for an Adverse Benefit Determination of Experimental or Investigational treatment and the Covered Person's treating physician certifies in writing that the recommended Health Care Service or treatment would be significantly less effective if not promptly initiated.

   NOTE: An expedited external review is not available for retrospective Final Adverse Benefit Determinations (meaning the Health Care Service has already been provided to the Covered Person).

2. **External Review by the Ohio Department of Insurance**

   A Covered Person is entitled to an external review by the Department in either of the following instances:

   - The Adverse Benefit Determination is based on a contractual issue that does not involve a medical judgment or medical information.

- The Adverse Benefit Determination for an Emergency Medical Condition indicates that medical condition did not meet the definition of emergency AND The Claims Administrator's decision has already been upheld through an external review by an IRO.

D. Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Ohio Department of Insurance, the Covered Person, or an Authorized Representative, must request an external review through The Claims Administrator within 180 days from your receipt of the notice of Final Adverse Benefit Determination.

All requests must be in writing, including by electronic means, except for a request for an expedited external review. Expedited external reviews may be requested orally. The Covered Person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete and eligible The Claims Administrator will initiate the external review and notify the Covered Person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the Covered Person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. The Claims Administrator will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete, The Claims Administrator will inform the Covered Person in writing and specify what information is needed to make the request complete. If The Claims Administrator determines that the Adverse Benefit Determination is not eligible for external review, The Claims Administrator must notify the Covered Person in writing and provide the Covered Person with the reason for the denial and inform the Covered Person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by The Claims Administrator and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the Health Benefit Plan and all applicable provisions of the law.

E. IRO Assignment

When The Claims Administrator initiates an external review by an IRO, the Ohio Department of Insurance web-based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of Health Care Service. An IRO that has a conflict of interest with The Claims Administrator, the Covered Person, the health care provider or the health care facility will not be selected to conduct the review.

F. Reconsideration by The Claims Administrator

If you submit information to the Independent Review Organization or the Ohio Department of Insurance to consider, the Independent Review Organization or Ohio Department of Insurance will forward a copy of the information to The Claims Administrator. Upon receipt of the information, The Claims Administrator may reconsider its Adverse Benefit Determination and provide coverage for the Health Care Service in question. Reconsideration by The Claims Administrator will not delay or terminate an external review. If The Claims Administrator reverses an Adverse Benefit Determination, The Claims Administrator will notify you in writing and the Independent Review Organization will terminate the external review.

G. IRO Review and Decision

The IRO must consider all documents and information considered by The Claims Administrator in making the Adverse Benefit Determination, any information submitted by the Covered Person and other information such as; the Covered Person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the Health Benefit Plan, the most appropriate practice guidelines, clinical review criteria used by the Health Plan Issuer or its Utilization Review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by The Claims Administrator of a request for a standard review or within 72 hours of receipt by The Claims Administrator of a request for an expedited review. This notice will be sent to the Covered Person, The Claims Administrator and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review
- The date the Independent Review Organization was assigned by the Ohio Department of Insurance to conduct the external review
- The dates over which the external review was conducted
- The date on which the Independent Review Organization's decision was made
- The rationale for its decision
- References to the evidence or documentation, including any evidence-based standards, that were used or considered in reaching its decision

NOTE: Written decisions of an IRO concerning an Adverse Benefit Determination that involves a health care treatment or service that is stated to be Experimental or Investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

H. Binding Nature of External Review Decision

An external review decision is binding on The Claims Administrator except to the extent The Claims Administrator has other remedies available under state law. The decision is also binding on the Covered Person except to the extent the Covered Person has other remedies available under applicable state or federal law.

A Covered Person may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to The Claims Administrator.

I. If You Have Questions About Your Rights or Need Assistance

You may contact The Claims Administrator at the Customer Service telephone number listed on your identification card. You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, Ohio 43215-4186
Telephone: 800.686.1526 / 614-644-2673
Fax: 614-644-3744
TDD: 614-644-3745

Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Claim Review

Consent to Release Medical Information - Denial of Coverage

You consent to the release of medical information to The Claims Administrator and the Plan when you enroll in The Plan.

When you present your identification card for Covered Services, you are also giving your consent to release medical information to The Claims Administrator. The Claims Administrator 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, The Claims Administrator will review the claim to ensure that the service was Medically Necessary and that all other conditions for coverage are satisfied. The fact that a Provider may recommend or prescribe treatment does not mean that it is automatically a Covered Service or that it is Medically Necessary.

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

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

Legal Actions

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

Coordination of Benefits

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

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

Definitions

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

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

   When T**his Plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This Plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable Expense**.

4. **Allowable Expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable Expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable Expense**. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an **Allowable Expense**.

   The following are examples of expenses that are not **Allowable Expenses**:

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

5. **Closed Panel Plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.
6. **Custodial Parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order Of Benefit Determination Rules

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

1. The **Primary Plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.
2. a. Except as provided in Paragraph "b" below, a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
   b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed Panel Plan** to provide out-of-network benefits.
3. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
4. Each **Plan** determines its order of benefits using the first of the following rules that apply:
   a. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the **Primary Plan** and the **Plan** that covers the person as a dependent is the **Secondary Plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary Plan** and the other **Plan** is the **Primary Plan**.

b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order of benefits is determined as follows:
    1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
        - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary Plan**; or
        - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary Plan**.
        - However, if one parent's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
    2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
        a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
        b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
        c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
        d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            - The **Plan** covering the **Custodial Parent**;
            - The **Plan** covering the spouse of the **Custodial Parent**;
            - The **Plan** covering the **Non-Custodial Parent**; and then
            - The **Plan** covering the spouse of the **Non-Custodial Parent**.
    3. For a dependent child covered under more than one **Plan** of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

Effect On The Benefits Of This Plan

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

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Coordination Disputes

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

Subrogation and Right of Recovery

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan’s right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. “You” or “your” includes anyone on whose behalf the Plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan’s right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. Benefit payments made under the Plan are conditioned upon your obligation to reimburse the Plan in full from any full or partial recovery you receive for your injury, illness or condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the Plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Future Benefits

If you fail to cooperate with and reimburse the Plan, the health plan reserves the right to deny any future benefit payments on any other claim made by you until the Plan is reimbursed in full. However, the amount of any covered services excluded under this section will not exceed the amount of your recovery.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Discretionary Authority

The Plan 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. The Plan's determination will be final and conclusive.

Right of Recovery

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

Changes In Benefits or Provisions

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

Termination of Coverage

How and When Your Coverage Stops

Your coverage, as described in this Benefit Book, stops:

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

Federal Continuation Provisions - COBRA

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

When You Are Eligible for COBRA

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

1. the death of your spouse;
2. the termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. divorce or legal separation from your spouse;
4. your spouse becomes entitled (that is, covered) under Medicare; or

5. your spouse is retired, and your spouse's employer filed for reorganization under Chapter 11 of the Bankruptcy Code, and your spouse was covered by the Plan on the date before the commencement of bankruptcy proceeding and was retired from the employer.

In the case of an Eligible Dependent of a Cardholder, (active employee for number six (6) below) covered by the Plan, he or she has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

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

Notice Requirements

Under COBRA, the Cardholder or Eligible Dependent has the responsibility to inform the employer of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of any such event. If notice is not received within that 60-day period, the dependent will not be entitled to choose continuation coverage. When the employer is notified that one of these events has happened, the COBRA administrator 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 the COBRA administrator 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 end of the month of the qualifying event.

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

How Long COBRA Coverage Will Continue

COBRA requires that you be offered the opportunity to maintain continuation coverage for 18 months if you lost coverage under the Plan due to the Cardholder's termination (for reasons other than gross misconduct) or reduction in work hours. A Cardholder's covered spouse and/or Eligible Dependents are required to be offered the opportunity to maintain continuation coverage for 36 months if coverage is lost under the Plan because of an event other than the Cardholder'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 Cardholder) to his own continuation coverage (for example, the former Cardholder dies, is divorced or legally separated, becomes entitled to Medicare or the dependent ceased to be an Eligible Dependent under the Plan), the continuation coverage may be extended for the affected qualified beneficiary. However, in no case will any period of continuation coverage be more than 36 months.

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

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

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

Additional Information

An Eligible Dependent, who is a qualified beneficiary, is entitled to elect continuation of coverage even if the Cardholder does not make that election. At subsequent open enrollments, an Eligible Dependent may elect a different coverage from the coverage the Cardholder elects.

You do not have to provide proof of insurability to obtain continuation coverage. However, under COBRA, you will have to pay all of the premium (both employer and employee portion) for your continuation coverage, plus a 2% administrative fee. You will have an initial grace period of 45 days (starting with the date you choose continuation coverage) to pay any premiums then due; after that initial 45-day grace period, you will have a grace period of 30 days to pay any subsequent premiums.

It is your employer's responsibility to advise you of your COBRA rights and notify the COBRA administrator of the qualifying event. The COBRA administrator will provide you access to enroll.

Continuation of Coverage During Military Service

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

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

Rescission of Coverage

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

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage.

PRESCRIPTION DRUG BENEFIT

Your Prescription Drug benefit is administered by CVS/Caremark.

	Retail	Mail Order
When to use your benefit:	For immediate or short-term medications.	For maintenance or long-term medications**
Where:	To locate a CVS/ Caremark participating retail network pharmacy in your area, simply click on "Find a Local Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-888-202-1654.	Have your provider send your prescription(s) to CVS/ Caremark Mail Order. Your medicines will be sent directly to a location of your choice.
Refill Limits	One initial fill plus 1 refill for long-term medications**	Four 90-day fills per calendar year.
Days Supply:	34 days	90 days
Your Coinsurance (financial responsibility)	Generics 20% Coinsurance* Preferred Brands 20% Coinsurance Non-Preferred Brands 30% Coinsurance** Specialty Drugs 30% Coinsurance (Member receives medication at $0 after enrolled in PrudentRx) (See Specialty Drugs section under “Getting Your Prescription Filled Through CVS/Caremark’s Mail Order Program”) 100% of the cost of long-term drugs that are filled at a retail pharmacy more than 2 times.***	

* If you are prescribed a Preferred Brand drug and a Generic is available, the prescription will be filled with the Generic drug. If you choose to have the prescription filled with the Brand drug, you will pay 100% and the amount you pay will not be applied toward your out-of-pocket maximum.

** If you are prescribed a Non-Preferred Brand drug, you will receive a tier change letter from CVS and be provided with the option to change to a Preferred Brand/Generic. If you choose to continue with the Non-Preferred Brand drug, you will pay 30% Coinsurance. Your out-of-pocket maximums will still apply.

*** A long-term medicine is taken regularly for chronic conditions or long-term therapy. A few examples include medicines for managing high blood pressure, asthma, diabetes or high cholesterol.

When you need to take your maintenance medicine right away, ask your doctor for two prescriptions:

1. The first for up to a 34-day supply at retail and one refill at retail.
2. The second for up to a 90-day supply at mail order with refills when clinically appropriate.

Have the short-term supply filled immediately at an in-network retail pharmacy and send the 90-day supply prescription to the CVS/Caremark Mail Service Pharmacy.

Getting Your Short-Term Prescription Filled at a Retail Pharmacy

Day Supply Limit

You can get up to a 34-day supply of medicine each time you have a prescription filled at a participating retail pharmacy. Ask your doctor to write a prescription for up to a 34-day supply plus refills, when clinically appropriate. Keep in mind; if you are taking long-term medications each one must be filled at CVS/Caremark's mail order facility after the initial fill plus 1 refill.

If You Use a Non-Caremark Pharmacy

You must pay 100 percent of the prescription price. You will then need to submit a paper claim form along with the original prescription receipt(s) to CVS/Caremark for reimbursement of Covered Services. You can download and print a claim form when you log in to www.caremark.com or call the Customer Care toll-free number (available 24/7) on your benefit I.D. card.

For Reimbursement under the Medical Plan

You do not need to file a claim with the Claims Administrator in order for your prescription costs to be credited toward your Coinsurance out-of-pocket maximum.

Prescription drug information is sent by CVS/Caremark to the Claims Administrator on a regular basis. The Claims Administrators process the claims.

Getting Your Prescription Filled Through CVS/Caremark's Mail Order Program

To ensure your safety, CVS Caremark's mail service pharmacies are staffed by registered pharmacists. Just like your neighborhood pharmacist, CVS Caremark's pharmacists check each prescription to make sure it is filled correctly. In addition, your prescription history is reviewed to identify any possible problems with new medicines you may be prescribed.

Day Supply Limit

You can get up to a 90-day supply of medicine when you get your prescription filled through the CVS Caremark Mail Service Pharmacy. Ask your doctor to electronically submit your 90-day prescription with refills when clinically appropriate.

Please Note: By law, CVS Caremark must fill your prescription for the exact quantity of medicine prescribed by your doctor, up to the 90-day supply limit.

Re-Order Options

There are several ways to reorder your mail prescriptions:

1. You will receive a new mail service order form with each order you received.
2. You can go to CareMark.com and register as a user. Then you can see what prescriptions are available for refill and click on them to reorder.
3. You can set up Auto Refill – Caremark will then send your prescriptions to you automatically when they are ready to be refilled until you have no refills left.

Convenient Home Delivery

You can expect your medicine to arrive approximately 10 calendar days after CVS Caremark receives your prescription. You will also receive the same type of information about your prescribed medicine that you would receive from a retail pharmacy.

Eligibility

Prescription drug coverage is available to the Employee and any Dependents who are "primary" under the Employee's coverage. For definition of "primary" see the Coordination of Benefits section.

Secondary Coverage

To file a claim for secondary coverage, you will need to submit a paper claim form along with the original prescription receipt(s) and primary coverage Explanation of Benefits or receipt to AultCare or Medical Mutual for reimbursement of Covered Services.

Specialty Drugs

For Specialty medications, contact CVS/Caremark Specialty Pharmacy at 800-237-2767.

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, the Group has contracted to offer the PrudentRx Solution for certain specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses to $0.

All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication. If you do not call PrudentRx, PrudentRx will reach out to you to assist with questions and enrollment. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% coinsurance on specialty medications that are eligible for the PrudentRx Solution.

Additional Covered Services

This is a summary of the Affordable Care Act Preventive Care requirements and not intended to be an exhaustive list. This list is subject to change upon issuance of additional regulations and guidance.

The following prescription drugs are not subject to the prescription drug coinsurance when filled by a CVS/Caremark network pharmacy:

- Prescribed generic prescription drug contraceptives or brand name prescription drug contraceptives when an equivalent generic prescription drug contraceptive is not available
- Preventative care vaccines, including immunizations for flu (i.e., Fluzone) and shingles (i.e., Zostavax)
- Your coverage also provides benefits for certain preventive drugs required by PPACA, when a written prescription from your Prescriber is received. These PPACA-required drugs are covered at a zero Copayment, but specific patient conditions may apply.

Non-Covered Services

- Male contraceptive and over the counter birth control without a prescription
- Over the counter drugs or supplies
- Weight loss products and/or anti-obesity medications
- Medical devices or supplies – may be covered under medical plan
- Rogaine
- Retin A over age 26
- Growth Hormones
- Cosmetic
- Diabetic Supplies – may be covered under medical plan
- Non-insulin needles and syringes
- Specialty Drugs that are not obtained through CVS/ Caremark's Specialty Pharmacy

Drugs purchased at CVS/Caremark Retail Pharmacy when insurance I.D. is not used for primary coverage (no reimbursement for paper claim).

Medication Exceptions/Appeals Process

For questions regarding medication exceptions/appeals process, call the CVS Customer Care unit, 1-888-202-1654. Once a call is received, an exception fax form or ePA request is sent to the physician's office. For Urgent requests, CVS will process within 72 hours of receipt of the request, however, their standard is 24 hours once all information is received. For Non-urgent requests, CVS will process within 15 days, but their standard is within 72 hours from receipt of all necessary information.

Internal Appeal Procedures

Mandatory Internal Appeal Level

If your claim is denied and you wish to have the claim reconsidered, you, or your authorized representative on your behalf, may appeal the denial and request a review of your claim. Your appeal must be received by the Pharmacy Benefit Manager within 180 days after your receipt of the notice of denial.

When you submit your appeal, you may also submit additional comments, records and documents related to your claim. You may also, upon request and at no charge, review copies of the documents and information relevant to your claim.

Appeals should include the following information:

- name of the participant who is the subject of the appeal;
- the participant's CVS Caremark ID number;
- the participant's date of birth;
- a written statement of the issue(s) being appealed;
- name of the drug(s) being requested; and
- written comments, documents, records or other information relating to the claim being appealed.

Your appeal and supporting documentation may be mailed or faxed to the Pharmacy Benefit Manager as follows:

CVS Caremark, Inc.
Appeals Department
MC109
PO Box 52084
Phoenix, AZ 85072-2084
Fax Number for Appeals: (866) 443-1172

Expedited Internal Appeal

Note that the Plan provides for an expedited review process with respect to urgent care claims. You may request an expedited appeal of an Adverse Benefit Determination orally or in writing. The expedited process allows you to transmit and receive information from the Plan by telephone, facsimile or other similar expedited means. [Physicians may submit urgent appeal requests by calling the physician-only toll-free number at 1-866-443-1183.]

Notification of the Plan's Determination After Appeal

If your appeal is received by the appropriate deadline, the Pharmacy Benefit Manager will independently review your appeal and any additional information that you submit. The Pharmacy Benefit Manager will notify you of its decision regarding your appeal within the following timeframes:

1. ***Urgent Care Claims*** – as soon as possible, but no later than 72 hours after receipt of your appeal.
2. ***Pre-Service Claims*** – within a reasonable period, but no later than 30 days after receipt of your appeal.
3. ***Post-Service Claims*** – within a reasonable period, but no later than 60 days after receipt of your appeal.

With respect to any appeal that is based in whole or in part on a medical judgment, including determinations with respect to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Pharmacy Benefit Manager delegates its fiduciary decision-making authority to one of its outside vendors. In rendering its decision on Plan coverage, the outside vendor, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Pharmacy Benefit Manager will identify the medical or other experts who provided advice to the Plan with respect to your claim. The

Pharmacy Benefit Manager currently uses the following vendors for such appeals: AllMed Healthcare Management, Inc., Medical Review Institute of America, Inc., Network Medical Review Co., MES Solutions, MCMC, LLC. However, the outside vendors used by the Pharmacy Benefit Manager may change from time to time. The vendors used by the Pharmacy Benefit Manager are considered "named fiduciaries" of the Plan.

Content of Notification

If your appeal is denied, the Pharmacy Benefit Manager will send you a statement containing: (i) specific reasons for the denial, (ii) specific references to relevant Plan provisions, (iii) a statement that you may have access to or receive, upon request and at no charge and copies of all documents, records and information relevant to your claim. In addition to the information above, the notice will contain any information regarding an internal rule, guideline or protocol used in making the appeal decision and an explanation of the scientific or clinical judgment used in the denial. If the appeal notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge. If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination. If the appeal notice does not contain such explanation, it will contain a statement indicating that this explanation is available upon written request and at no charge.

The Pharmacy Benefit Manager will provide to you, free of charge, any new or additional evidence or any new or additional rationale, that is considered, relied upon or generated by the Plan (or at the direction of the Plan) in connection with your claim. In order to give you an opportunity to respond to such new or additional evidence or the new or additional rationale, this evidence or rationale will be provided to you in advance of the date on which you are to receive a decision on your appeal (as described above). You may review your claim file and present evidence and testimony relevant to your claim.

What Happens After the Mandatory Internal Appeal Level

If your claim is denied at the mandatory internal appeal level, you may be eligible for either the External Review Process by an Independent Review Organization for Adverse Benefit Determinations involving medical judgment or the External Review Process by the Ohio Department of Insurance for contractual issues that do not involve medical judgment.

External Appeal Procedures

Possible Right to External Appeal

If your appeal is denied, you may pursue an external review of your claim by an independent, third party if your claim denial involved either medical judgment (such as a denial based on medical necessity, appropriateness, health care setting, level of care, or effectiveness, or a determination that the treatment is experimental or investigational) or a rescission of coverage.

Standard External Review

If you wish to pursue an external appeal, you must file a request for an external appeal within four (4) months of the date your appeal was denied.

The request for an external appeal should include:

- the participant's name,
- contact information including mailing address and daytime telephone number,
- the participant's ID number, and
- a copy of the prior appeal denial.

The request for an external appeal and supporting documentation may be mailed or faxed to the Pharmacy Benefit Manager as follows:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-3092
Fax Number: (866) 689-3092

Within five (5) days after its receipt of a request for an external appeal, the Pharmacy Benefit Manager will confirm whether your request is complete and eligible for an external appeal. If the request is complete and eligible for an external appeal, the Pharmacy Benefit Manager will forward the request to an Independent Review Organization ("IRO"), together with all relevant medical records, all other documents relied upon by the Pharmacy Benefit Manager in making a decision on the case, and all other information or evidence that you or your physician has already submitted to the Pharmacy Benefit Manager. If there is any information or evidence you or your physician wishes to submit in support of the request that was not previously provided, you may include such information with the request for an external appeal.

Except in the case of an expedited external appeal, as described below, the assigned IRO will provide you and the Plan with written notice of its decision on your external appeal within 45 days of its receipt of your request. If the IRO needs additional information to make a decision, this time period may be extended as permitted by law. The IRO's notice to you shall also include such other information as required by applicable law.

Expedited External Appeal

The external appeal process will be expedited if you meet the criteria for an expedited external appeal, as defined by applicable law. For example, if you have received an Adverse Benefit Determination that involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal, you may expedite your external appeal as well. Similarly, if you have received a final denial of your claim under the internal appeal procedures and you have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or your claim involved an admission, availability of care, continued stay, or a prescription drug benefit for which you received emergency treatment, but have not been discharged from a facility, you may expedite your external appeal.

You or your physician may request an expedited external appeal by calling the CVS Caremark Information number on your Plan ID card. The request should include:

- the participant's name,
- contact information including mailing address and daytime telephone number,
- the participant's ID number, and
- a copy of the prior appeal denial.

Alternatively, a request for an expedited external appeal and the supporting documentation may be faxed to the Pharmacy Benefit Manager at:

CVS Caremark
External Review Appeals Department
Fax number: (866) 443-1172

All requests for an expedited external appeal must be clearly identified as "urgent" at the time of submission.

Immediately upon its receipt of a request for an expedited external appeal, the Pharmacy Benefit Manager will confirm whether your request is complete and eligible for an external appeal. If the request is complete and eligible for an external appeal, the Pharmacy Benefit Manager will forward the request to an IRO, together with all relevant medical records, all other documents relied upon by the Pharmacy Benefit Manager in making a decision on the case, and all other information or evidence that you or your physician has already submitted to the Pharmacy Benefit Manager. If there is any information or evidence you or your physician wishes to submit in support of the request that was not previously provided, you may include this information with the request for an external appeal.

The assigned IRO will provide you and the Plan with notice of its decision on your external appeal as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external appeal. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide you and the Plan with written confirmation of its decision. The IRO's notice shall also include such other information as required by applicable law.

Final Decision of IRO

If the final independent decision of the IRO is to approve payment/coverage of the benefit that was previously denied, the Plan will accept the decision and provide coverage for your prescription drug in accordance with the terms and conditions of the Plan except to the extent the Claims Administrator has other remedies available under state law. If the final independent decision of the IRO is that payment/coverage will not be made or provided, the Plan will not be obligated to provide coverage for the prescription drug except to the extent the Covered Person has other remedies available under applicable state or federal law.

A Covered Person may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to The Plan Administrator.

Please contact The Claims Administrator or the Pharmacy Benefit Manager for more information on filing an external appeal.

If You Have Questions About Your Rights or Need Assistance

You may contact The Claims Administrator at the CVS Caremark Information telephone number listed on your identification card. You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
20 West Town Street, Suite 300
Columbus, Ohio 43215-4186

Telephone: 800-686-1526/614-644-2673
Fax: 614-644-3744
TDD: 614-644-3745

Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

AultCare/Aultra General Tag Lines for the State of Ohio

English

If you, or someone you are helping, have questions about **AultCare/Aultra** you have the right to get help and information in your language at no cost. To speak with an interpreter, call **Local: 330.363.6360 Outside Stark County: 1.800.344.8858 TTY Local: 711 Outside Stark County: 711**

Spanish

Español

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca **AultCare/Aultra** tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al **Local: 330.363.6360 Fuera del condado de Stark: 1.800.344.8858 TTY Local: 711 Fuera del condado de Stark: 711**

Chinese

中文

如果您，或是您正在協助的對象，有關於**AultCare/Aultra保险公司** 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 本地： **330.363.6360 斯塔克縣外： 1.800.344.8858 TTY線 本地： 711斯塔克縣外： 711** 。

German

Deutsche

Falls Sie oder jemand, dem Sie helfen, Fragen zum **AultCare/Aultra** haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY –Linie Local: 711 Außerhalb von Stark County : 711** an.

Arabic

العربية

العربية، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب
AultCare/Aultra إن كان لديك أو لدى شخص تساعده أسئلة بخصوص شركة التأمين
خارج مقاطعة ستارك . 711 المحلي: 711 الخط **TTY** خارج مقاطعة ستارك : 330.363.6360 1.800.344.8858

Pennsylvania Dutch

Deitsch

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut **AultCare/Aultra** hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du **Local: 330.363.6360 Außerhalb von Stark County: 1.800.344.8858 TTY –Linie Local: 711 Außerhalb von Stark County: 711** uffrufe.

Russian

русский

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу **Страховая компания AultCare/Aultra**, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону **Местный: 330.363.6360 Вне Старка County : 1.800.344.8858 TTY линия Местный: 711 Вне Старка County : 711.**

French

Français

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de **Compagnie d'Assurance AultCare/Aultra**, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, **Appelez Locale 330.363.6360 En dehors du comté de Stark: 1.800.344.8858 ligne ATS Local: 711 En dehors du comté de Stark: 711**.

Vietnamese

Việt Nam

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về **Công ty Bảo hiểm AultCare/Aultra** quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi **Địa phương: 330.363.6360 Bên ngoài của Stark County: 1.800.344.8858 TTY đường dây Địa phương: 711 Bên ngoài của Stark County: 711.**

Cushite-Oromo

Isin yookan namni biraa isin deeggartan **AultCare/Aultra,** irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan

keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa **Local: 330.363.6360 Outside of Stark County: 1.800.344.8858 TTY Line Local: 711 Outside of Stark County: 711** tiin bilbilaa.

Korean

한국어

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이**AultCare/Aultra 보험 회사** 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 **지역 : 330.363.6360 스타크 카운티 의 외부 : 1.800.344.8858 TTY 라인 지역 : 711 스타크 카운티 의 외부 : 711** 로 전화하십시오.

Italian

Italiano

Se tu o qualcuno che stai aiutando avete domande su **AultCare/Aultra**, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare **Locale: 330.363.6360 Al di fuori di Stark County : 1.800.344.8858 TTY linea Locale: 711 Al di fuori di Stark County : 711.**

Japanese

日本語

ご本人様、またはお客様の身の回りの方でもAultCare/Aultra保険会社についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、 ローカル： **330.363.6360 スターク郡の外： 1.800.344.8858 TTYライン ローカル： 711 スターク郡の外： 711までお電話ください。**

Dutch

Nederlands

Als u, of iemand die u helpt, vragen heeft over **AultCare/Aultra,** heeft u het recht om hulp en informatie te krijgen in uw taal zonder kosten. Om te praten met een tolk, bel **Local : 330.363.6360 Buiten Stark County : 1.800.344.8858 TTY Line Local : 711 Buiten Stark County : 711.**

Ukrainian

український

Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про **Страхова компанія AultCare/Aultra,** у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на **Місцевий : 330.363.6360 Поза Старка County : 1.800.344.8858 TTY лінія Місцевий : 711 Поза Старка County : 711.**

Romanian

Română

Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind **Compania de Asigurari AultCare/Aultra**, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la **Locale : 330.363.6360 In afara Stark Judet : 1.800.344.8858 TTY linie Locale : 711 In afara Stark Judet : 711.**

Non-Discrimination Notice:

AultCare/Aultra complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AultCare/Aultra does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AultCare/Aultra provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). AultCare/Aultra provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, or if you believe that AultCare/Aultra has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can contact or file a grievance with the: AultCare/Aultra Civil Rights Coordinator, 2600 6th St. S.W. Canton, OH 44710, 330-363-7456, CivilRightsCoordinator@aultcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

STARK COUNTY SCHOOLS
Council of Governments (COG)

DENTAL BENEFITS

Group Numbers
418470
418472

EFFECTIVE 1.1.2024

DENTAL SCHEDULE OF BENEFITS

Benefit Period	Calendar year
Benefit Period Deductible	$25 single / $75 family
Maximum Benefit Payable per Covered Person per Benefit Period	$3,000
Dependent Age Limit	The end of the month of the 26th birthday

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

Type of Service	**Maximums and Limitations**
Routine Preventive Services*	
Initial and Periodic Oral Evaluations	Two evaluations per Benefit Period
Bitewing x-rays	Two sets per Benefit Period
Prophylaxis	Two per Benefit Period
Topical Fluoride Applications	Two per Benefit Period
Essential Services*	
Full mouth / Panoramic x-rays	One every 36 months
Complex Services*	
Inlays	Once every five years per tooth
Onlays	Once every five years per tooth
Crowns	Once every five years per tooth
Fixed Partial Dentures (Bridges)	Once every five years per unit
Dentures (Complete and Partial)	Once every five years Relining and rebasing is covered if done no less than six months after initial placement but not more than once in any 36-month period. One replacement of a temporary denture if a permanent denture is installed within 12 months of the installment of the temporary denture.

* See dental payment schedule for member cost share and additional services covered under the preventive, essential and complex services benefit.

DENTAL PAYMENT SCHEDULE	
Type of Service	**You Pay the Following**
Routine Preventive Services (1)	
• Initial and periodic oral evaluations • Bitewing x-rays • Prophylaxis • Space maintainers • Topical fluoride applications • Emergency palliative treatments • Full mouth/panoramic x-rays • Diagnostic x-rays	0% of Traditional Amount No Deductible is required for these services.
Essential Services (1)	
• Consultations/other evaluations • Fillings • Endodontic services • Periodontal services • Extractions • Impactions • Repairs, relines & adjustments of prosthetics • General anesthesia • IV sedation • Minor oral surgery	20% of Traditional Amount
Complex Services (1)	
• Inlays • Onlays • Crowns • Fixed partial dentures (bridges) • Dentures (complete & partial)	20% of Traditional Amount
Orthodontic Services	40% of Traditional Amount

ORTHODONTIC SERVICES	
Maximum benefit payable per Covered Person	$2,000 per lifetime
Eligibility	Available for all Covered Persons, regardless of age.
Deductible	No Deductible is required for Orthodontic services.

NETWORK OPTION

Superior Dental Care Network Option - As a Stark County Schools Council of Governments member you have the freedom to choose any dentist and receive these benefits. You have the option to receive covered dental services from a dentist who participates in the Superior Dental Care Network. Choosing to receive covered dental services from a Superior Dental Care network provider protects you from balance bills (the difference between the amount paid by Medical Mutual and providers billed amount). Superior Dental Care providers agree to accept Medical Mutual's payment and not bill Stark County School's members for the balance.

To view the participating dentists and specialists in your area, visit: MedMutual.com/SDCnetwork

Notes:

1. Not all services within a category of dental services (e.g., Routine preventive, Essential, Complex) are covered. For specific coverage questions, please contact Customer Care at the phone number shown on your identification card.

DENTAL BENEFIT BOOK

This Benefit Book describes the dental benefits available to you as a Covered Person in the Self-Funded Dental Benefit Plan (the Plan) offered to you by your Employer through Stark County Schools COG (the Group).

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

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

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

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

HOW TO USE YOUR BENEFIT BOOK

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

The **Schedule of Benefits** gives you information about the limits and maximums of your coverage and explains your Coinsurance, Copayment and Deductible obligations, if applicable.

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

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

The **Dental 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 Dental Benefits section.

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

DEFINITIONS

Active Treatment - the treatment of adjusting an Orthodontic appliance to apply effective force to the teeth or jaws.

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

Benefit Book - this document.

Benefit Period - the period of time specified in the Schedule of Benefits during which Covered Services are rendered and benefit maximums 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 Dental Provider, whether they are a Covered Service or not.

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

Coinsurance - a percentage of the Traditional Amount for Covered Services for which you are responsible after you have met your Deductible.

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

Course of Treatment - a planned series of procedures or treatments performed by a Dental Provider.

Covered Charges - the Billed Charges for Covered Services.

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

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

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 the Plan will start to provide benefits.

Dental Provider - a Dentist or Physician who provides Covered Services as described in the Dental Benefits section of this document.

Dental Specialist - an oral surgeon, endodontist, periodontist, prosthodontist or orthodontist.

Dentist - a licensed professional who treats diseases and injuries to the teeth and oral cavity.

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

Emergency Palliative Dental Treatment - treatment given in response to a painful or dangerous situation to relieve pain and remove a person from immediate danger without rendering definitive treatment (such as a filling).

Enrollment Application - a form (paper or electronic) you complete for yourself and your Eligible Dependents to be considered for coverage under the Plan.

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

Experimental or Investigational Drug, Device, Dental Treatment or Procedure - a drug, device, dental 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, dental 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, dental 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 dental 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, dental treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, dental treatment or procedure. Determination will be made by Medical Mutual at its sole discretion and will be final and conclusive, subject to any available appeal process.

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

Immediate Family - the Cardholder and the Cardholder'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 Dental 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.

Medically Necessary (Medical Necessity) - a service or supply that is required to diagnose or treat a Condition and which Medical Mutual determines is:

- appropriate with regard to the standards of good dental practice;
- not primarily for your convenience or the convenience of a Dental Provider; and
- the most appropriate supply or level of service which can be safely provided to you.

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.

Orthodontics - the specialty and practice of preventing and correcting irregularities of the teeth, as by braces.

Periodontal Services - procedures including examination, diagnosis and treatment (including Surgery) of disease affecting the surrounding and supporting tissues of the teeth.

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

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

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

Retention Treatment - the period of Orthodontic treatment during which the individual is wearing an appliance to maintain the teeth in position.

Rider - a document that amends or supplements your coverage.

Surgery -

- the performance of generally accepted operative and other invasive procedures of the teeth, bone and soft tissue of the oral structures;
- referring specifically to the operative/cutting procedure of the teeth, bone and soft tissue of the oral structures which are considered within the scope or practice by the provider's license and specialty and/or as determined by the State Dental Board;
- utilized to correct pathology as a result of decay, fracture, damage, loss and infection that would necessitate tissue removal, prosthesis placement, placement of dental materials and medicaments and/or tissue architecture modifications;
- usual and related preoperative and postoperative care; or
- other procedures as reasonably approved by Medical Mutual.

The Claims Administrator – The selected carrier assigned to administer your benefit, i.e.: Medical Mutual.

Traditional Amount - the maximum amount determined and allowed by Medical Mutual for a Covered Service 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 Value Scale (RBRVS)
- other fee schedules
- input from Participating Dental Providers and wholesale prices (where applicable)
- geographic considerations; and
- other economic and statistical indicators and applicable conversion factors.

ELIGIBILITY

Enrolling for Coverage

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

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

Eligible Employees

An Eligible Employee is:

An employee of the Group who meets the eligibility requirements of the Group including working the required number of hours that the Group requires for eligibility. Any applicable waiting period must be satisfied, but will not exceed 90 days.

No person who is eligible to enroll will be denied enrollment based upon health status, health care needs, genetic information, previous medical information, disability or age.

Eligible Dependents

An Eligible Dependent is:

- the Cardholder's spouse:
  - provided you are not legally separated
- the Cardholder's or spouse's:
  - natural children;
  - children placed for adoption and legally adopted children;
  - children for whom either the Cardholder or Cardholder's spouse is the Legal Guardian or Custodian; or
  - any children who, by court order, must be provided health care coverage by the Cardholder or Cardholder's spouse.
- the Cardholder's stepchildren, provided the natural parent remains married to the Cardholder and resides in the household.

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

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

Child Support Order

In general, a medical child support order is a court order that requires an Eligible Employee to provide medical coverage for his or her children in situations involving divorce, legal separation or paternity dispute. A medical child support order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. This Plan provides benefits according to the requirements of a medical child support order that is entered by a court of competent jurisdiction or by a local child support enforcement agency. The Group will promptly notify affected Cardholders if a medical child support order is received. Once the dependent child is enrolled under a medical child support order, the child's appointed guardian will receive a copy of all pertinent information provided to the Eligible Employee. In addition, should the Eligible Employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

Effective Date

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

Changes in Coverage

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 employer's benefit administrator who must then notify Medical Mutual of the change.

Coverage for a spouse and other Eligible Dependents who become eligible by reason of marriage will be effective on the date of the marriage if a request for their coverage is submitted to the Group within 31 days of marriage.

A newborn child or an adopted child will be covered as of the date of birth or adoptive placement, provided that you request enrollment within 31 days of the date of birth or adoptive placement. Coverage will continue for an adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

It is important to complete and submit your Enrollment application promptly, because the date this new coverage begins will depend on when you request enrollment.

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

Your Identification Card

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

Your identification card is the property of The Claims Administrator 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.

DENTAL BENEFITS

This section describes the services and supplies covered if provided and billed by a Dental Provider. When alternate methods of treatment are available, the allowable amount will be based on the least costly method of treatment that Medical Mutual deems appropriate and Medically Necessary. All Covered Services must be Medically Necessary.

The following are Covered Services:

- initial and periodic oral evaluations
- bitewing x-rays
- prophylaxis (cleaning)
- topical fluoride applications
- space maintainers
- Emergency Palliative Treatment, including emergency oral evaluations
- diagnostic x-rays
- full mouth/panoramic x-rays
- consultations and other evaluations by a Dental Specialist
- minor restorative services, including, but not limited to, fillings made of amalgam or resin-based composites
- endodontic procedures, including pulpotomy, root canal treatment and apicoectomy (removal of the apex of the tooth root)
- Periodontal Services, including removal of gum tissue around the necks of the teeth and the recontouring of the gum tissue
- repairs, relines and adjustments of prosthetics (complete and partial dentures, crowns, fixed partial dentures (bridges))
- extractions, including simple and surgical extractions and impactions
- minor oral Surgery, including alveoloplasty (Surgery performed on the alveolar bone, including flap entry and closure) and vestibuloplasty
- general anesthesia for a covered oral or dental Surgery
- inlays
- onlays
- crowns that are not part of a fixed partial denture, including stainless steel crowns
- prosthetics, including complete dentures, fixed partial dentures (bridges), and removable partial dentures, are subject to the following:
    - If an appliance can be made serviceable, a replacement appliance is not covered. Refer to the Schedule of Benefits for more details.
    - Coverage is limited to standard procedures. Personalized restorations and specialized techniques in constructing dentures or fixed partial dentures are not covered.
- Orthodontic services consisting of installing tooth straightening appliances and all treatments for abnormally positioned teeth, are subject to the following limitations:
    - Benefits for Orthodontic services will be provided only as services are Incurred.
    - When you are already receiving Active or Retention Treatment on your Effective Date, only services Incurred after your Effective Date will be covered based on a proration of the expected months of treatment.

EXCLUSIONS

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

1. Not prescribed by or performed by or under the direction of a Dental Provider.
2. Not performed within the scope of the Dental Provider's license.
3. For congenital or developmental malformation or other services primarilyPor to improve appearance.
4. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
5. For a Condition that occurs as a result of any act of war, declared or undeclared.
6. For which you have no legal obligation to pay in the absence of this or like coverage.
7. 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.
8. Incurred or received after you stop being a Covered Person.
9. Received from a member of your Immediate Family.
10. 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.
11. For charges in excess of the amount Medical Mutual determines to be allowable.
12. Rendered by more than one Dental Provider. If you change Dental Providers during a Course of Treatment or if more than one Dental Provider treats you for a procedure, additional benefits are not provided.
13. For appliances or restorations needed to increase or restore the vertical dimension or to restore and/or correct the occlusion.
14. For missed appointments, completion of claim forms or copies of medical records.
15. For the repair of a damaged space maintainer or replacement of a lost or stolen space maintainer.
16. For Outpatient educational, vocational, or training purposes except as may be specified.
17. Received in a military facility for a military service-related Condition.
18. For which payment was made or would have been made under Medicare Part 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.
19. For Experimental or Investigational Drugs, Devices, Dental Treatments or Procedures.
20. For fraudulent or misrepresented claims.
21. For personalized restorations, specialized techniques in constructing dentures or partial fixed dentures or replacement of appliances that can be made serviceable.
22. For instruction for plaque control, oral hygiene and diet.
23. For implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.
24. For non-Covered Services or services specifically excluded in the text of this Benefit Book.

GENERAL PROVISIONS

HOW TO APPLY FOR BENEFITS

Notice of Claim; Claim Forms

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

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

Proof of Loss

Proof of Loss is a claim for payment of dental 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 Dental Provider's notes or other medical records before Proof of Loss is considered sufficient to determine benefit coverage.

Medical Mutual is not legally obligated to reimburse on behalf of the Plan for Covered Services unless 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.

HOW CLAIMS ARE PAID

Benefit Period Deductible

Each Benefit Period, you must pay the dollar amount specified in the Schedule of Benefits as the Deductible before the Plan will begin to provide benefits. This is the amount of expense that must be Incurred and paid by you for Covered Services before the Plan starts to provide benefits. 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's 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.

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.

Coinsurance

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

Schedule of Benefits

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

The Schedule of Benefits shows your financial responsibility for Covered Services. The Plan covers the remaining liability for Covered Charges after you have paid the amounts indicated in the Schedule of Benefits subject to benefit maximums.

Your Financial Responsibilities

You are responsible for paying 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 Dental Provider does not accept the Traditional Amount as payment in full. Your financial responsibilities include the Deductible amounts specified in the Schedule of Benefits. Coinsurance is also your responsibility. In cases where there are alternate methods of treatment with different fees, and you select the more expensive treatment or service, you are responsible for all charges in excess of the allowable amount deemed appropriate and Medically Necessary by Medical Mutual.

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

Direction of Payment

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

Medical Mutual is authorized to make payments directly to Dental 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 Dental Provider and neither Medical Mutual nor the Group are legally obligated to pay any additional amounts. You cannot assign your right to receive payment to anyone else, nor can you authorize someone else to receive your payments for you, including your Dental Provider.

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 on behalf of the Group, and you must repay this amount when requested.

Explanation of Benefits

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

Time of Payment of Claims

Benefits will be provided under this Benefit Book within 30 days after receipt of a completed claim. 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 Cardholder should have the following information available:

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

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

Quality of care issues are addressed by Medical Mutual's Quality Improvement Department or committee.

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

BENEFIT DETERMINATION FOR CLAIMS (INTERNAL CLAIMS PROCEDURE)

Claims Involving Urgent Care

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

Determination of **urgent** will be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any Dentist or Physician with a knowledge of the claimant's medical Condition can also determine that a claim involves urgent care.

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

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

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

Concurrent Care Claims

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

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

Pre-Service Claims

A Pre-Service Claim is a claim for a benefit which requires some form of preapproval or precertification by Medical Mutual.

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

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

Post-Service Claims

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

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

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

Benefit Determination Notices

You will receive notice of a benefit determination orally, as allowed, or in writing. 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;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of Medical Mutual's appeal procedures, applicable timeframes, including the expedited appeal process, if applicable;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the adverse benefit determination was based on Medical Necessity, Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

FILING AN APPEAL

If you are not satisfied with a benefit or medical necessity determination decision, you may file an appeal.

To file an appeal, contact the telephone number or address on your current identification card or Explanation of Benefits and provide the following information: Cardholder'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 Department
P.O. Box 94580
Cleveland, Ohio 44101-4580
Fax: (216) 687-7990

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

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

Mandatory Internal Appeal

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

First level mandatory appeals must be filed within 180 days from your receipt of the notice of denial of benefits. All requests for appeal may be made by submitting an electronic form, by calling Customer Service or in writing as described above.

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

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

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

The appeal procedures are as follows:

Appeal of a Claim Involving Urgent Care

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

Pre-Service Claim Appeal

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

Post Service Claim Appeal

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

All notices of a denial of benefit after an appeal will include the following:

- the specific reason for the denial;
- sufficient information to identify the claim or health care service involved, including the date of services, the health care provider, and the claim amount (if applicable);

- statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits;
- 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 adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- if the adverse benefit determination was based on a Medical Necessity, Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request; and
- a description of applicable appeal procedures.

CLAIM REVIEW

Consent to Release Medical and Dental Information - Denial of Coverage

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

When you present your identification card for Covered Services, you are also giving your consent to release medical and dental 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 and dental 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 Dental Provider may recommend or prescribe treatment does not mean that it is automatically a Covered Service or that it is Medically Necessary.

LEGAL ACTIONS

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

COORDINATION OF BENEFITS

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

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

Definitions

1. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
    a. **Plan** includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual

automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

b. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under "a" or "b" above is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

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

   When **This Plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This Plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable Expense**.

4. **Allowable Expense** is a dental care expense, including Deductibles and Coinsurance, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable Expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable Expense**. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an **Allowable Expense**.

   The following are examples of expenses that are not **Allowable Expenses**:

   a. If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable Expense**.
   b. If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable Expense**.
   c. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary Plan's** payment arrangement shall be the **Allowable Expense** for all **Plans**. However, if the Provider has contracted with the **Secondary Plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary Plan's** payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the **Allowable Expense** used by the **Secondary Plan** to determine its benefits.
   d. The amount of any benefit reduction by the **Primary Plan** because a Covered Person has failed to comply with the **Plan** provisions is not an **Allowable Expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

Order Of Benefit Determination Rules

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

1. The **Primary Plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.
2. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
3. Each **Plan** determines its order of benefits using the first of the following rules that apply:
   a. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the **Primary Plan** and the **Plan** that covers the person

as a dependent is the **Secondary Plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary Plan** and the other **Plan** is the **Primary Plan**.

b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order of benefits is determined as follows:

   1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary Plan**; or
      - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary Plan**.
      - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
   2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
      b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
      c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
      d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         - The **Plan** covering the **Custodial Parent**;
         - The **Plan** covering the spouse of the **Custodial Parent**;
         - The **Plan** covering the N**on-Custodial Parent**; and then
         - The **Plan** covering the spouse of the **Non-Custodial Parent**.
   3. For a dependent child covered under more than one **Plan** of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

Effect On The Benefits Of This Plan

1. When **This Plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable Expenses**. In determining the amount to be paid for any claim, the **Secondary Plan** will calculate the benefits it would have paid in the absence of other dental coverage and apply that calculated amount to any **Allowable Expense** under its **Plan** that is unpaid by the **Primary Plan**. The **Secondary Plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary Plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable Expense** for that claim. In addition, the **Secondary Plan** shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526 or visit the Department's website at http://insurance.ohio.gov.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. Benefit payments made under the Plan are conditioned upon your obligation to reimburse the Plan in full from any full or partial recovery you receive for your injury, illness or condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the Plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents

agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Future Benefits

If you fail to cooperate with and reimburse the Plan, the health plan reserves the right to deny any future benefit payments on any other claim made by you until the Plan is reimbursed in full. However, the amount of any covered services excluded under this section will not exceed the amount of your recovery.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Discretionary Authority

The Plan 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. The Plan's determination will be final and conclusive.

Right of Recovery

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

CHANGES IN BENEFITS OR PROVISIONS

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

TERMINATION OF COVERAGE

How and When Your Coverage Stops

Your coverage, as described in this Benefit Book, stops:

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

Federal Continuation Provisions - COBRA

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

When You Are Eligible for COBRA

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

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

In the case of an Eligible Dependent of a Cardholder, (active employee or Eligible Dependent of a Cardholder covered by the Plan, he or she has the right to continuation coverage if group dental coverage under the Plan is lost for any of the following reasons:

1. the death of the Cardholder;
2. the termination of the Cardholder's employment (for reasons other than gross misconduct) or reduction in the Cardholder's hours of employment;

3. the Cardholder's divorce or legal separation;
4. the Cardholder becomes entitled (that is, covered) under Medicare;
5. the dependent ceases to be an "Eligible Dependent;" or
6. the Cardholder is retired and the Cardholder's group files for reorganization under Chapter 11 of the Bankruptcy Code.

Notice Requirements

Under COBRA, the Cardholder or Eligible Dependent has the responsibility to inform the employer of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of any such event. If notice is not received within that 60-day period, the dependent will not be entitled to choose continuation coverage. When the employer is notified that one of these events has happened, the COBRA administrator 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 the COBRA administrator 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 end of the month of the qualifying event.

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

How Long COBRA Coverage Will Continue

COBRA requires that you be offered the opportunity to maintain continuation coverage for 18 months if you lost coverage under the Plan due to the Cardholder's termination (for reasons other than gross misconduct) or reduction in work hours. A Cardholder's covered spouse and/or Eligible Dependents are required to be offered the opportunity to maintain continuation coverage for 36 months if coverage is lost under the Plan because of an event other than the Cardholder'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 Cardholder) to his own continuation coverage for up to 36 months from the date of entitlement (for example, the former Cardholder dies, is divorced or legally separated, or the dependent ceased to be an Eligible Dependent under the Plan), the continuation coverage may be extended for the affected qualified beneficiary. However, in no case will any period of continuation coverage be more than 36 months.

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

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

1. your employer no longer provides group dental 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 dental plan (unless that other Plan contains an exclusion or limitation with respect to any preexisting Condition affecting you or a covered dependent); or
4. you first become, after the date of election, entitled (that is covered) under Medicare.

Additional Information

An Eligible Dependent, who is a qualified beneficiary, is entitled to elect continuation of coverage even if the Cardholder does not make that election. At subsequent open enrollments, an Eligible Dependent may elect a different coverage from the coverage the Cardholder elects.

You do not have to provide proof of insurability to obtain continuation coverage. However, under COBRA, you will have to pay all of the premium (both employer and employee portion) for your continuation coverage, plus a 2% administrative fee. You will have an initial grace period of 45 days (starting with the date you choose continuation coverage) to pay any premiums then due; after that initial 45-day grace period, you will have a grace period of 30 days to pay any subsequent premiums. (During the last 180 days of your continuation coverage period, you must be allowed to enroll in an individual conversion health plan if one is provided by the Group. However, conversion coverage is not available if the Agreement terminates or the Group goes out of business. Call the Group during your last 180 days of COBRA for information on conversion).

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

Continuation of Coverage During Military Service

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

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

STARK COUNTY SCHOOLS
Council of Governments (COG)

VISION BENEFITS PLAN

Group Numbers
418470
418472

EFFECTIVE 1.1.2024

VISION SCHEDULE OF BENEFITS

Benefit Period	Rolling 12 months
Dependent Age Limit	The end of the month of the 26th birthday

It is important that you understand how the Claims Administrator, 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 Paid at 100%
Frames	One Frame every rolling 24 months $170 per Frame
Lenses	One pair per Benefit Period Single Vision: $75 per pair Bifocals: $100 per pair Trifocals: $125 per pair Lenticular: $200 per pair
Contact Lenses	One pair per Benefit Period (1) Medically Necessary: $150 allowance Cosmetic: $400 allowance

Notes

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

VISION CARE BENEFIT BOOK

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

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

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

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

HOW TO USE YOUR BENEFIT BOOK

This Benefit Book describes your vision benefits. Please read it carefully.

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

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

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

The **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.

DEFINITIONS

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

Benefit Book - this document.

Benefit Period - the period of time specified in the Schedule of Benefits during which Covered Services are rendered and benefit maximums 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.

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

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.

Covered Charges - the Billed Charges for Covered Services.

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

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

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

Enrollment Application - a form (paper or electronic) you complete for yourself and your Eligible Dependents to be considered for coverage under the Plan.

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, subject to any available appeal process.

Frame - standard eyeglasses excluding the Lenses.

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

Immediate Family - the Cardholder and the Cardholder'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 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 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.

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

Provider - Physician or Other Professional Provider.

Rider - a document that amends or supplements your coverage.

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.

The Claims Administrator – The selected carrier assigned to administer your benefit, i.e.: 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.

ELIGIBILITY

Enrolling for Coverage

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

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

Eligible Employees

An Eligible Employee is:

An employee of the Group who meets the eligibility requirements of the Group including working the required number of hours that the Group requires for eligibility. Any applicable waiting period must be satisfied, but will not exceed 90 days.

No person who is eligible to enroll will be denied enrollment based upon health status, health care needs, genetic information, previous medical information, disability or age.

Eligible Dependents

An Eligible Dependent is:

- the Cardholder's spouse:
  - provided you are not legally separated
- the Cardholder's or spouse's:
  - natural children;
  - children placed for adoption and legally adopted children;
  - children for whom either the Cardholder or Cardholder's spouse is the Legal Guardian or Custodian; or
  - any children who, by court order, must be provided health care coverage by the Cardholder or Cardholder's spouse.
- the Cardholder's stepchildren, provided the natural parent remains married to the Cardholder and resides in the household.

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

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

Child Support Order

In general, a medical child support order is a court order that requires an Eligible Employee to provide medical coverage for his or her children in situations involving divorce, legal separation or paternity dispute. A medical child support order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. This Plan provides benefits according to the requirements of a medical child support order that is entered by a court of competent jurisdiction or by a local child support enforcement agency. The Group will promptly notify affected Cardholders if a medical child support order is received. Once the dependent child is enrolled under a medical child support order, the child's appointed guardian will receive a copy of all pertinent information provided to the Eligible Employee. In addition, should the Eligible Employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

Effective Date

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

Changes in Coverage

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 employer's benefits administrator who must then notify Medical Mutual of the change.

Coverage for a spouse and other Eligible Dependents who become eligible by reason of marriage will be effective on the date of the marriage if a request for their coverage is submitted to the Group within 31 days of marriage.

A newborn child or an adopted child will be covered as of the date of birth or adoptive placement, provided that you request enrollment within 31 days of the date of birth or adoptive placement. Coverage will continue for an adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

It is important to complete and submit your Enrollment application promptly, because the date this new coverage begins will depend on when you request enrollment.

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

Your Identification Card

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

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

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, the Plan 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 - The Plan 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, 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 LASIK eye surgery or laser vision correction.
10. For safety glass and safety goggles.
11. For tints other than Number One or Two.
12. For tints with photosensitive or antireflective properties.
13. 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.
14. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
15. For which you have no legal obligation to pay in the absence of this or like coverage.
16. Received from a medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
17. For an eye examination or materials ordered as a result of an eye examination prior to your Effective Date.
18. Incurred or received after you stop being a Covered Person.
19. Received from a member of your Immediate Family.
20. For a Condition that occurs as a result of any act of war, declared or undeclared.
21. For 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 Benefit Book.

GENERAL PROVISIONS

HOW TO APPLY FOR BENEFITS

Notice of Claim; Claim Forms

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

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

Proof of Loss

Proof of loss is a claim for payment of 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 on behalf of the Plan 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.

HOW CLAIMS ARE PAID

Schedule of Benefits

The Schedule of Benefits shows the maximum benefits Medical Mutual will pay for Covered Services.

Your Financial Responsibilities

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

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, benefit maximums will be calculated as described in this Benefit Book.

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

Medical Mutual has and retains the sole right to choose which Providers it will contract with, and on what terms, and to amend and terminate those contracts. MMO 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 neither Medical Mutual nor the Plan are legally obligated to pay any additional amounts. You cannot assign your right to receive payment to anyone else, nor can you authorize someone else to receive your payments for you.

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 on behalf of the Plan, 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 provided to you electronically or by mail. It lists Covered Services and non-covered services along with explanations for why services are not covered. It contains important amounts and a telephone number if you have any questions.

Time of Payment of Claims

Benefits will be provided under this Benefit Book within 30 days after receipt of a completed claim. 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 Cardholder should have the following information available:

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

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

Quality of care issues are addressed by Medical Mutual’s Quality Improvement Department or committee.

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

BENEFIT DETERMINATION FOR CLAIMS

Claims Involving Urgent Care

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

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

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

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

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

Concurrent Care Claims

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

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

Pre-Service Claims

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

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

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

Post-Service Claims

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

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

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

Adverse Benefit Determination Notices

You will receive notice of a benefit determination, orally as allowed, or in writing. All notices of an adverse benefit determination will include the following:

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

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: Cardholder'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 Department
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.

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

Mandatory Internal Appeal

The Plan offers you a mandatory internal appeal. You must complete this mandatory internal appeal before any additional action is taken.

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

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

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

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

The appeal procedures are as follows:

Appeal of a Claim Involving Urgent Care

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

Pre-Service Claim Appeal

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

Post Service Claim Appeal

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

All notices of a final adverse benefit determination after an appeal will include the following:

- the specific reason(s) for the adverse benefit determination;
- reference to the specific plan provision(s) on which the adverse benefit determination is based;
- sufficient information to identify the claim or health care service involved, including the date of services, the health care provider, and the claim amount (if applicable);
- statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;

- if the adverse benefit determination was based on a Medical Necessity, Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request; and
- a description of applicable appeal procedures.

CLAIM REVIEW

Consent to Release Medical Information - Denial of Coverage

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

When you present your identification card for Covered Services, you are also giving your consent to release medical and vision 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 against Medical Mutual or The Plan to recover benefits within 60 days after Medical Mutual receives written proof in accordance with this Benefit Book that Covered Services have been given to you. No such action may be brought later than three years after expiration of the required claim filing limit as specified in the Proof of Loss section.

COORDINATION OF BENEFITS

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

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

Definitions

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

Each contract for coverage under "a" or "b" above is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

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

   When **This Plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This Plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable Expense**.

4. **Allowable Expense** is a vision expense, including Deductibles, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable Expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable Expense**. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an **Allowable Expense**.

   The following are examples of expenses that are not **Allowable Expenses**:

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

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

Order Of Benefit Determination Rules

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

1. The **Primary Plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.
2. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
3. Each **Plan** determines its order of benefits using the first of the following rules that apply:
   a. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the **Primary Plan** and the **Plan** that covers the person as a dependent is the **Secondary Plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary Plan** and the other **Plan** is the **Primary Plan**.

b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order of benefits is determined as follows:
    1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
        - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary Plan**; or
        - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary Plan**.
        - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
    2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
        a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
        b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
        c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
        d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            - The **Plan** covering the **Custodial Parent**;
            - The **Plan** covering the spouse of the **Custodial Parent**;
            - The **Plan** covering the N**on-Custodial Parent**; and then
            - The **Plan** covering the spouse of the **Non-Custodial Parent**.
    3. For a dependent child covered under more than one **Plan** of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

Effect On The Benefits Of This Plan

1. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable Expenses**. In determining the amount to be paid for any claim, the **Secondary Plan** will calculate the benefits it would have paid in the absence of other vision coverage and apply that calculated amount to any **Allowable Expense** under its **Plan** that is unpaid by the **Primary Plan**. The **Secondary Plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary Plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable Expense** for that claim. In addition, the **Secondary Plan** shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other vision coverage.

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526 or visit the Department's website at http://insurance.ohio.gov.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. Benefit payments made under the Plan are conditioned upon your obligation to reimburse the Plan in full from any full or partial recovery you receive for your injury, illness or condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the Plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Future Benefits

If you fail to cooperate with and reimburse the Plan, the health plan reserves the right to deny any future benefit payments on any other claim made by you until the Plan is reimbursed in full. However, the amount of any covered services excluded under this section will not exceed the amount of your recovery.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Discretionary Authority

The Plan 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. The Plan's determination will be final and conclusive.

Right of Recovery

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

CHANGES IN BENEFITS OR PROVISIONS

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

TERMINATION OF COVERAGE

How and When Your Coverage Stops

Your coverage, as described in this Benefit Book, stops:

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

Federal Continuation Provisions - COBRA

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

When You Are Eligible for COBRA

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

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

In the case of an Eligible Dependent of a Cardholder, (active employee or Eligible Dependent of a Cardholder covered by the Plan, he or she has the right to continuation coverage if group vision coverage under the Plan is lost for any of the following reasons:

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

Notice Requirements

Under COBRA, the Cardholder or Eligible Dependent has the responsibility to inform the employer of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of any such event. If notice is not received within that 60-day period, the dependent will not be entitled to choose continuation coverage. When the employer is notified that one of these events has happened, the COBRA administrator 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 the COBRA administrator of your election of continuation coverage.

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

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

How Long COBRA Coverage Will Continue

COBRA requires that you be offered the opportunity to maintain continuation coverage for 18 months if you lost coverage under the Plan due to the Cardholder's termination (for reasons other than gross misconduct) or reduction in work hours. A Cardholder's covered spouse and/or Eligible Dependents are required to be offered the opportunity to maintain continuation coverage for 36 months if coverage is lost under the Plan because of an event other than the Cardholder'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 Cardholder) to his own continuation coverage for up to 36 months from the date of entitlement (for example, the former Cardholder dies, is divorced or legally separated, or the dependent ceased to be an Eligible Dependent under the Plan), the continuation coverage may be extended for the affected qualified beneficiary. However, in no case will any period of continuation coverage be more than 36 months.

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

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

1. your employer no longer provides group vision 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 vision plan (unless that other Plan contains an exclusion or limitation with respect to any preexisting Condition affecting you or a covered dependent); or
4. you first become, after the date of election, entitled (that is covered) under Medicare.

Additional Information

An Eligible Dependent, who is a qualified beneficiary, is entitled to elect continuation of coverage even if the Cardholder does not make that election. At subsequent open enrollments, an Eligible Dependent may elect a different coverage from the coverage the Cardholder elects.

You do not have to provide proof of insurability to obtain continuation coverage. However, under COBRA, you will have to pay all of the premium (both employer and employee portion) for your continuation coverage, plus a 2% administrative fee. You will have an initial grace period of 45 days (starting with the date you choose continuation coverage) to pay any premiums then due; after that initial 45-day grace period, you will have a grace period of 30 days to pay any subsequent premiums. (During the last 180 days of your continuation coverage period, you must be allowed to enroll in an individual conversion health plan if one is provided by the Group. However, conversion coverage is not available if the Agreement terminates or the Group goes out of business. Call the Group during your last 180 days of COBRA for information on conversion).

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

Continuation of Coverage During Military Service

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

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

Multi-Language Interpreter Services & Nondiscrimination Notice

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

Spanish

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

Chinese

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

German

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

Arabic

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

Pennsylvania Dutch

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

Russian

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

French

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

Vietnamese

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

Navajo

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

Oromo

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

Korean

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

Italian

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

Japanese

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

Dutch

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

Ukrainian

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

Romanian

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

Tagalog

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

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

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

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

Nondiscrimination Notice

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

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

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

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

Email: CivilRightsCoordinator@MedMutual.com

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

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

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