

## **HIGHWAY PATROL RETIREMENT SYSTEM - RETIREES**

**Group Number  
229040-001, 007, 009**



# PPO Network Major Medical Health Care Benefit Book

## Hearing Rider

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

# TABLE OF CONTENTS

<b>SCHEDULE OF BENEFITS</b> .....	2
<b>PPO NETWORK MAJOR MEDICAL HEALTH CARE BENEFIT BOOK</b> .....	8
<b>HOW TO USE YOUR BENEFIT BOOK</b> .....	9
<b>DEFINITIONS</b> .....	10
<b>ELIGIBILITY</b> .....	18
<b>HEALTH CARE BENEFITS</b> .....	21
Alcoholism and Drug Abuse Services.....	21
Allergy Tests and Treatments.....	21
Ambulance Services.....	21
Case Management.....	22
Clinical Trial Programs.....	22
Christian Science Sanatoria.....	23
Dental Services for an Accidental Injury.....	24
Diagnostic Services.....	24
Drugs and Biologicals.....	24
Emergency Services.....	25
Home Health Care Services.....	25
Hospice Services.....	26
Inpatient Health Education Services.....	26
Inpatient Hospital Services.....	26
Inpatient Physical Medicine and Rehabilitation Services.....	27
Maternity Services, including Notice required by the Newborns' and Mothers' Protection Act.....	27
Medical Care.....	28
Medical Supplies and Durable Medical Equipment.....	29
Mental Health Care Services.....	31
Nutritional Counseling Services.....	32
Organ Transplant Services.....	32
Other Outpatient Services.....	33
Outpatient Institutional Services.....	33
Outpatient Rehabilitative Services.....	34
Preventive and Wellness Services.....	34
Private Duty Nursing Services.....	36
Skilled Nursing Facility Services.....	36
Surgical Services.....	36
Temporomandibular Joint Syndrome Services.....	37
Urgent Care Services.....	37
<b>EXCLUSIONS</b> .....	38
<b>GENERAL PROVISIONS</b> .....	41
How to Apply for Benefits.....	41
How Claims are Paid.....	41
Review of Benefit Determinations.....	45
Claim Review.....	47
Legal Actions.....	48
Coordination of Benefits.....	48
Subrogation and Right of Recovery.....	51
Changes In Benefits or Provisions.....	53
Termination of Coverage.....	53
<b>HEARING SCHEDULE OF BENEFITS</b> .....	55
<b>HEARING SERVICES RIDER</b> .....	56
HEARING SERVICES.....	56
DEFINITIONS.....	56

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## SCHEDULE OF BENEFITS

To receive the highest level of benefits at the lowest Out-of-Pocket Maximum expense, Covered Services must be provided by PPO Network Providers. When you use Non-Contracting Providers, you are responsible for any balance due between the Provider's charge and the Allowed Amount, in addition to any Deductibles, Copayments, Coinsurance, and non-covered charges. 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" for additional information.

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

### BENEFIT PERIOD AND DEPENDENT AGE LIMIT

Benefit Period	Calendar year
Dependent Age Limit	The end of the month of the 26th birthday

### COMPREHENSIVE MAJOR MEDICAL BENEFIT

<b>Deductible per Benefit Period for PPO Network Providers</b>	
For each Covered Person:	\$1,500
<b>Deductible per Benefit Period for Contracting, Non-PPO Network Providers and Non-Contracting Providers</b>	
For each Covered Person:	\$2,000
<b>Coinsurance Limit per Benefit Period for PPO Network Providers</b>	
For each Covered Person:	\$2,500
<b>Coinsurance Limit per Benefit Period for Contracting, Non-PPO Network Providers and Non-Contracting Providers</b>	
For each Covered Person:	\$6,000
<b>Out-of-Pocket Maximum per Benefit Period for PPO Network Providers</b> (Includes Deductibles, Copayments, and Coinsurance)	
For each Covered Person:	\$4,000
<b>Out-of-Pocket Maximum per Benefit Period for Contracting, Non-PPO Network Providers and Non-Contracting Providers</b> (Includes Deductibles, Copayments, and Coinsurance)	
For each Covered Person:	\$8,000

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.

The Deductible, if applicable, Coinsurance Limit and Out-of-Pocket Maximum that applies to PPO Network Providers accumulates separately from the Deductible, Coinsurance Limit and Out-of-Pocket Maximum that applies to Non-PPO Network Providers and Non-Contracting Providers.

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

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

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

<b>BENEFIT MAXIMUMS PER COVERED PERSON</b>	
(per Benefit Period unless otherwise shown)	
Chiropractic/Spinal Manipulation Visits	10 visits
Human Papillomavirus (HPV) Tests	One test every three Benefit Periods
Outpatient Professional Occupational and Physical Therapy Services	10 visits (combined), then subject to medical review
Outpatient Speech Therapy Services	20 visits
Preventive Bone Density Tests (Females, age 65 and over)	One test
Preventive Colon Cancer Screen (age 45 to 75)	One screening
Preventive Colonoscopy Tests (age 45 to 75)	One every 10 Benefit Periods
Preventive Mammogram Services and Associated Examination (age 50 to 74)	One mammogram; mammograms are limited to 130% of the Medicare reimbursement amount; the maximum reimbursement amount applies only to Covered Services received inside the state of Ohio, as mandated by the state of Ohio.  One examination
Preventive Pap Tests and associated examination (age 21 to 65)	One test and examination every three Benefit Periods
Preventive Physical Examinations (age 21 and over) • (received from other than the Ohio Health Westerville Medical Campus)	Males • One examination  Females • Two examinations
Preventive Physical Examinations (age 21 and over) • Performed at the Ohio Health Westerville Medical Campus (2) <b>(Limited to the Retiree and Spouse Only)</b>	One examination every 24 months
Preventive Sigmoidoscopy Tests (age 45 to 75)	One every five Benefit Periods
Skilled Nursing Facility Services	90 days per Confinement
Well Child Care Hearing Examinations	One exam per Birth Year; limited to only the following ages: newborn infants, four (4), five (5), six (6), eight (8) and ten (10)
Wigs	One every two Benefit Periods

<b>MAXIMUM LIFETIME BENEFIT PER COVERED PERSON</b>	
Experimental and Investigational Services	\$10,000
Weight loss surgery (including repairs, revisions or modifications)	\$20,000
Well Child Care Examinations	31 visits



<b>COINSURANCE AND COPAYMENTS FOR COVERED SERVICES</b>		
<b>TYPE OF SERVICE (Institutional and Professional)</b>	<b>For Covered Services received from a PPO Network Provider, you pay the following portion, based on the Allowed Amount</b>	<b>For Covered Services received from a Non-PPO Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (2)(3)</b>
<b>IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.</b>		
<b>EMERGENCY ROOM SERVICES</b>		
The Institutional charge for use of the Emergency Room for an Emergency Medical Condition	\$200 Copayment, waived if admitted, then 20%	
All other related Institutional charges for an Emergency Medical Condition	\$200 Copayment, waived if admitted, then 20% (Copayment combined with Emergency Room Copayment)	
All other related Emergency Room Physician's charges for an Emergency Medical Condition	20%	
The Institutional charge for use of the Emergency Room in a <b>non-emergency</b>	\$450 Copayment, waived if admitted, then 20%	
Emergency Room Physician's Charges in a <b>non-emergency</b>	20%	40%
<b>INPATIENT SERVICES</b>		
Maternity	20%	40%
Physical Medicine and Rehabilitation	20%	40%
Semi-Private Room and Board	20%	40%
Skilled Nursing Facility	20%	40%
<b>MENTAL HEALTH CARE, DRUG ABUSE AND ALCOHOLISM SERVICES</b>		
Mental Health Care, Drug Abuse and Alcoholism Services	Any applicable Deductible, Out-of-Pocket Maximum or Copayment corresponds to the type of service received and is payable on the same basis as any other illness (e.g., emergency room visits for a Mental Illness will be paid according to the Emergency Services section above).	
<b>OUTPATIENT REHABILITATIVE SERVICES</b>		
Cardiac Rehabilitation Services	20%	40%
Chiropractic Services	20%	40%
Occupational Therapy Services	20%	40%
Physical Therapy Services	20%	40%
Pulmonary Therapy Services	20%	40%
Respiratory Therapy Services	20%	40%
Speech Therapy Services	20%	40%

**COINSURANCE AND COPAYMENTS FOR COVERED SERVICES**

TYPE OF SERVICE (Institutional and Professional)	For Covered Services received from a PPO Network Provider, you pay the following portion, based on the Allowed Amount	For Covered Services received from a Non-PPO Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (2)(3)
<b>IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.</b>		
<b>PHYSICIAN/OFFICE SERVICES (includes Mental Health and Substance Abuse Disorders)</b>		
Medically Necessary Immunizations	20%	40%
Medically Necessary Office Visits (4)	\$20 Copayment	40%
Medically Necessary Office Visits in a Specialist's Office	\$45 Copayment, then 20%	40%
Urgent Care Office Visits	\$60 Copayment	40%
<b>PREVENTIVE AND WELLNESS SERVICES</b>		
Preventive Services are provided in accordance with state and federal law. Please refer to the "Preventive and Wellness Services" health care benefit for details. (5)	0%, not subject to the Deductible	40%
Laboratory, X-ray and Medical Testing Services	20%	40%
Physical Examinations (age 21 and over)	0%, not subject to the Deductible	40%
Physical Examinations (age 21 and over) <ul style="list-style-type: none"> <li>• Performed at the Ohio Health Westerville Medical Campus (2)</li> </ul> <b>(Limited to the Retiree and Spouse Only)</b>	0%, not subject to the Deductible	
Preventive Immunizations	0%, not subject to the Deductible	40%
Testing <ul style="list-style-type: none"> <li>• Bone density (females, age 65 and over)</li> <li>• Colon cancer screening (age 45 to 75)</li> <li>• Colonoscopy and Sigmoidoscopy (age 45 to 75)</li> <li>• Diabetes screening (age 40 to 70 if overweight or obese)</li> <li>• Human Papillomavirus (HPV) (age 30 and over)</li> </ul>	0%, not subject to the Deductible	40%
<b>SURGICAL SERVICES</b>		
Inpatient Surgery	20%	40%
Medically Necessary Endoscopic Procedures (i.e. Colonoscopy, Sigmoidoscopy, etc.)	20%	40%
Outpatient Surgery	20%	40%

**COINSURANCE AND COPAYMENTS FOR COVERED SERVICES**

<b>TYPE OF SERVICE (Institutional and Professional)</b>	<b>For Covered Services received from a PPO Network Provider, you pay the following portion, based on the Allowed Amount</b>	<b>For Covered Services received from a Non-PPO Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (2)(3)</b>
<b>IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.</b>		
<b>OTHER SERVICES</b>		
Home Health Care Services • First 100 days	0%	10%
Home Health Care Services • After the first 100 days	20%	40%
Hospice Services	0%	40%
Outpatient Maternity Services	0%	40%
Weight Loss Surgery	\$2,750 Copayment, does not apply to the Out-of-Pocket Maximum	\$2,750 Copayment, does not apply to the Out-of-Pocket Maximum, then 40%
All Other Covered Services	20%	40%

**Comprehensive Major Medical Notes**

- Ohio Health Westerville Medical Campus  
300 Polaris Parkway  
Westerville, Ohio 43082  
(approximately two miles east of I-71)  
Call 614-566-2222 Ext. 4795 to schedule.
- The Coinsurance percentage will be the same for Non-Contracting Providers as Non-PPO Network Providers, but for Non-Contracting Providers, you may still be subject to balance billing and/or Excess Charges. Payments to Contracting Non-PPO Network Providers are based on the Allowed Amount. Payments to Non-Contracting Providers are based on the Non-Contracting Amount.
- In circumstances where Medicare is the primary payer for a Covered Person, the out-of-network reductions shown in the Schedule of Benefits do not apply.
- Includes Office Visits to a Psychiatrist or Psychologist, Licensed Independent Social Worker, Licensed Professional Clinical Counselor, and Licensed Marriage-Family Therapist.
- 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.



# PPO NETWORK 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 Retirement System (the Group). This is not a summary plan description by itself. However, it may be attached to or included with a document prepared by your Group that is called a summary plan description.

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

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

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

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

## HOW TO USE YOUR BENEFIT BOOK

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

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

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

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

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

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

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

## DEFINITIONS

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

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

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

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

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

**Benefit Book** - this document.

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

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

**Biosimilar Prescription Drug** - a Prescription Drug that:

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

**Birth Year** - a 12 month rolling year beginning on the individual's birth date.

**Card Holder** - an Eligible Retiree 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.

**Christian Science Sanatoria** - any sanatoria maintained by and accredited by and under the jurisdiction of the Mother Church, the First Church of Christ Scientist in Boston, Massachusetts. The sanatoria must also have a written agreement for reimbursement with Medical Mutual. A Christian Science Sanatoria is not, other than incidentally, a place that provides:

- Custodial Care, ambulatory, or part-time care; or
- treatment of Mental Illness, Alcoholism, Drug Abuse or pulmonary tuberculosis.

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

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

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

**Confinement Period** - the period of time beginning when you enter a Skilled Nursing Facility and ending when you have been out of the Skilled Nursing Facility for 60 days.

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

**Contracting** - the status of a Provider:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

**Formulary** - a list of drugs that are covered under this plan.

**Group** - the Retirement System who enters into an Agreement with Medical Mutual for Medical Mutual to provide administrative services for such Retirement System's health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Negotiated Amount for Providers does not include adjustments and/or settlement due to prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations, performance withhold adjustments or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim. In addition, the Negotiated Amount for Prescription Drugs does not include Pharmacy rebates, volume-based credits or refunds or discount guarantees.

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

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

**Non-Contracting Amount** - subject to applicable law, the maximum amount allowed by Medical Mutual for Covered Services provided to Medical Mutual Covered Persons by a Non-Contracting Provider based on various factors, including, but not limited to, market rates for that service, Negotiated Amounts for that service, and Medicare reimbursement for

that service. The Non-Contracting Amount will likely be less than the Provider's Billed Charges. If you receive services from a Non-Contracting Provider, and you are balanced billed for the difference between the Non-Contracting Amount and the Billed Charges, you may be responsible for the full amount up to the Provider's Billed Charges, even if you have met your Out-of-Pocket Maximum.

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

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

**Non-Preferred Brand Name Prescription Drug** - a Brand Name Prescription Drug that is included in Medical Mutual's Formulary and is classified as "Non-Preferred."

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

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

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

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

- advanced nurse practitioner (A.N.P.);
- ambulance services;
- 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, other than those applicable to Prescription Drug benefits, Incurred in a Benefit Period by a Covered Person for Covered Services.

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

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

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

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

**PPACA** - Patient Protection and Affordable Care Act

**PPO Network** - a limited panel of Providers as designated by Medical Mutual known as a preferred provider organization.

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

**Preauthorization** - A decision by Medical Mutual that a health care service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. This is also referred to as "precertification" or "prior approval". Medical Mutual requires Preauthorization before you are admitted as an Inpatient in a Hospital or before you receive certain services, except for an Emergency Medical Condition. Payment of benefits is still subject to all other terms and conditions of the Plan.

**Preferred Brand Name Prescription Drug** - A Brand Name Prescription Drug that is included in Medical Mutual's Formulary and is classified as "Preferred."

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

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

**Professional** - a Physician or Other Professional Provider.

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

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

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

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

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

**Rider** - a document that amends or supplements your coverage.

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

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

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

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

**Specialty Prescription Drugs** - Prescription Drugs that:

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

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

**Substance Abuse** - Alcoholism and/or Drug Abuse.

**Surgery** -

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

**Telemedicine Services** - a mode of providing health care services through synchronous or asynchronous 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 the recipient is located.

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

- has consistent, fair and practical criteria for selecting patients for transplants;
- has a written agreement with an organization that is legally authorized to obtain donor organs; and

- complies with all federal and state laws and regulations that apply to transplants covered under this Benefit Book.

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

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

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

# ELIGIBILITY

## Enrolling for Coverage

Prior to receiving this Benefit Book, you enrolled, and were accepted or approved by your Group for individual coverage or family coverage. For either coverage, you may have completed an Enrollment Form. There may be occasions when the information on the Enrollment Form is not enough. The 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 Card Holder is covered. Under family coverage, the Card Holder and the Eligible Dependents who have been enrolled are covered.

## Eligible Retirees

An Eligible Retiree is:

An retiree of the Group who meets the eligibility requirements of the Group including working the required number of hours that the Group requires for eligibility.

## Eligible Dependents

An Eligible Dependent is:

- the Card Holder's spouse, provided you are not legally separated;
- the Card Holder's or spouse's:
  - natural children;
  - children placed for adoption and legally adopted children;
  - children for whom either the Card Holder or Card Holder's spouse is the Legal Guardian or Custodian; or
  - any children who, by court order, must be provided health care coverage by the Card Holder or Card Holder's spouse.
- the Card Holder's stepchildren, provided the natural parent remains married to the Card Holder 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 Card Holder for support due to a physical handicap or intellectual disability which renders them unable to support themselves. This incapacity must have started before the age limit was reached and must be medically certified by a Physician. You must notify your Group of the Eligible Dependent's desire to continue coverage within 31 days of reaching the limiting age. After a two-year period following the date the Eligible Dependent meets the age limit, the Plan may annually require further proof that the dependence and incapacity continue.

## Child Support Order

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

## Effective Date

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

## Changes in Coverage

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

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 Form promptly, because the date this new coverage begins will depend on when you request enrollment.

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

## Special Enrollment

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

1. In order to qualify for special enrollment rights because of loss of coverage, you or your Eligible Dependent must have had other group health plan coverage at the time coverage under this Benefit Book was previously offered. You or your Eligible Dependent must have also stated, in writing, at that time that coverage was declined because of the other coverage, but only if Medical Mutual required such a statement at the time coverage was declined, and you were notified of this requirement and the consequences of declining coverage at that time.
2. If coverage was non-COBRA, loss of eligibility or the Group's contributions must end. A loss of eligibility for special enrollment includes:
  - a. Loss of eligibility for coverage as a result of legal separation or divorce
  - b. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Benefit Book)
  - c. Death of an Eligible Employee
  - d. Termination of employment
  - e. Reduction in the number of hours of employment that results in a loss of eligibility for plan participation (including a strike, layoff or lock-out)
  - f. Loss of coverage that was one of multiple health insurance plans offered by an employer, and the Eligible Employee elects a different plan during an open enrollment period
  - g. An individual no longer resides, lives, or works in an HMO Service Area (whether or not within the choice of the individual), and no other benefit package is available to the individual through the other employer
  - h. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual
  - i. Termination of an employee's or dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)
  - j. The employee or dependent is determined to be eligible for premium assistance in the Group's plan under a Medicaid or CHIP plan
3. If you or your Eligible Dependent has COBRA coverage, the coverage must be exhausted in order to trigger a special enrollment right. Generally, this means the entire 18, 29 or 36-month COBRA period must be completed in order to trigger a special enrollment for loss of other coverage.



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

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

### **Your Identification Card**

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

Your identification card is the property of Medical Mutual 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-PPO 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 PPO Network.**

### Women's Health and Cancer Rights Act Notice

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

### Alcoholism and Drug Abuse Services

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

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

Inpatient admissions to a Hospital 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 PPO 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. 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.

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

It's important to note:

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

## Case Management

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

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

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

## Clinical Trial Programs

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

In order to be eligible for benefits, the Covered Person must meet the following conditions (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 PPO 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 PPO 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 the travel to or from a facility providing the Approved Clinical Trial;
- An item or drug provided by the Approved Clinical Trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by an entity other than Medical Mutual, including the sponsor of the Approved Clinical Trial;
- A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

## **Christian Science Sanatoria**

Coverage is also provided for Christian Science Sanatoria services. The same benefits available to an Inpatient of a Hospital are available to an Inpatient of a Christian Science Sanatorium. Any necessary care and treatment given by a Christian Science Sanatoria practitioner will also be covered. The Plan will provide benefits only during the time these facilities are entitled to receive payment under Medicare law.

No benefits are provided:

- once a patient can no longer improve from treatment for the current conditions as determined by Medical Mutual.
- for private duty nursing.
- for Custodial Care or care for someone's convenience.
- for the treatment of Drug Abuse, Alcoholism, Mental Illness or pulmonary tuberculosis.
- for radiological therapy.

## Dental Services for an Accidental Injury

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

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

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

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

## Diagnostic Services

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

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

## Drugs and Biologicals

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

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

Specialty Prescription Drugs require prior approval from Medical Mutual.

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

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

**Step Therapy:** a program to determine whether you qualify for coverage based upon certain information, such as medical history, drug history, age and gender. This program requires that you try another drug before the target drug will be covered under this plan, unless special circumstances exist. If your Physician believes that special circumstances exist and would like to request a step therapy exemption, he or she may request a coverage review by providing Medical Mutual with supporting documentation and rationale for the request. Medical Mutual 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. Medical Mutual 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 Medical Mutual 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. Medical Mutual 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; and
- notify Medical Mutual, by calling Customer Care at the phone number shown on your identification card, within 24 hours, or as soon as medically possible, if the nearest Hospital is not in the PPO Network.

**Care and treatment once you are Stabilized are not Emergency Services.** Continuation of care beyond that needed to evaluate or Stabilize your Emergency Medical Condition will be covered according to your Schedule of Benefits. Please refer to your Schedule of Benefits for a detailed coverage explanation.

## Home Health Care Services

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

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

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

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

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

## Hospice Services

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

The following Covered Services are considered hospice services:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- Prescription Drugs;
- oxygen and its administration;
- medical social services, such as the counseling of patients;
- home health aide visits when you are also receiving covered nursing or therapy services;
- acute Inpatient hospice services;
- respite care;
- dietary guidance; counseling and training needed for a proper dietary program;
- durable medical equipment; and
- bereavement counseling for family members.

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

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

## Inpatient Health Education Services

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

## Inpatient Hospital Services

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

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

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

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

- operating, delivery and treatment rooms and equipment;

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

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

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

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

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

**Coverage for Inpatient care is not provided when the services could have been performed on an Outpatient basis, and it was not Medically Necessary, as determined by the Plan, 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 PPO 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. 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 normal pregnancy, complications of pregnancy and routine nursery care for a well newborn are covered.

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



Perinatal Care. Please note that neither you nor your Provider is required to obtain prior approval of an Inpatient maternity stay that falls within these time frames.

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

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

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

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

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

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

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

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

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, Medical Mutual 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 Medical Mutual 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

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

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

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

Staff consultations required by Hospital rules are not covered.

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

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

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

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

#### **Office Visits**

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

## **Medical Supplies and Durable Medical Equipment**

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

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

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

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

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

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

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

Covered DME includes:

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

- wheelchairs;
- hospital beds;
- crutches;
- mastectomy bras; and
- augmentive communication devices, when approved by Medical Mutual, based on the Covered Person's Condition.

### **Deluxe**

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

### **Repair/Warranty/Misuse**

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

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

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

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

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

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

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

These devices include, but are not limited to:

- Cervical collars;
- Ankle foot orthosis;
- Corsets (back and surgical);

- Splints (extremity);
- Trusses and supports;
- Slings;
- Wristlets;
- Built-up shoes; and
- Custom-made shoe inserts.

Covered Services for orthotic devices are:

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

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

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

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

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

Covered prosthetic appliances include:

- intraocular lens implantation for the treatment of cataract, aphakia or keratoconus;
- soft lenses or sclera shells for use as corneal bandages when needed as a result of eye Surgery;
- artificial hands, arms, feet, legs and eyes, including permanent lenses; and
- appliances needed to effectively use artificial limbs or corrective braces;
- wigs are covered when necessary due to:
  - alopecia;
  - diseases of the hair and hair follicles;
  - systemic lupus;
  - burn of face, head or scalp;
  - radiotherapy (radiation therapy); and
  - chemotherapy.

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

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

## Mental Health Care Services

Covered Services for the treatment of Mental Illness include:

- biofeedback;

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

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

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

Inpatient admissions to a Hospital Provider must be preauthorized. The telephone number for Preauthorization is listed on the back of your identification card. Contracting Providers and PPO 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. 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.

### Nutritional Counseling Services

Nutritional counseling services are only covered for the following:

- cardiovascular disease;
- diabetes mellitus;
- hypertension;
- kidney disease;
- eating disorders;
- gastrointestinal disorders; and
- seizures.

### 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 Medical Mutual.

Contracting Providers and PPO 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 Medical Mutual with:

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

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

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

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

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

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

## Other Outpatient Services

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

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

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

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

## Outpatient Institutional Services

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

**Covered Institutional services include, but are not limited to:**

- operating, delivery and treatment rooms and equipment;

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

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

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

## Outpatient Rehabilitative Services

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

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

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

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

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

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

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

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

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

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

## Preventive and Wellness Services

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

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for preventive use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

- With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration (HRSA).
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

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

- Health Education Services
  - Behavioral Counseling to Promote a Healthy Diet - Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases.
- Gynecological Services
  - Mammogram services; and
  - PAP tests and associated examinations.
- Physical Examinations
- Screenings
  - blood glucose screenings and screening for type 2 diabetes
  - bone density screenings for women
  - chlamydia screenings, limited to pregnant and sexually active women
  - cholesterol screenings
  - colorectal cancer screenings: using fecal occult blood testing, sigmoidoscopy or colonoscopy
  - hepatitis B virus screenings; limited to pregnant women in their first prenatal visit.
- Smoking cessation services
- Well child care services
- Women's preventive services
  - These services include, but are not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; 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](http://www.healthcare.gov/coverage/preventive-care-benefits). Newly added preventive services added by the advisory entities referenced by the Affordable Care Act will start to be covered on the first plan year beginning on or after the date that is one year after the new recommendations or guideline, went into effect. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of eligible services.

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

**Immunizations and Injections:** - The following are covered:

- Immunizations
- Tetanus Immune Globulin (TIG) and Diphtheria Antioxin

**Testing Services** - The following tests are covered:

- Bone density tests for woman age 65 and over
- Colon cancer screening, age 45 to 75
- Colonoscopy and sigmoidoscopy, age 45 to 75
- Diabetes screening; includes blood glucose screeng and electrolyte panel for age 40 to 70, if overweight or obese
- Human Papillomavirus (HPV) testing, age 30 and over
- Laboratory, x-ray and medical testing services
- Proctosigmoidoscopy



## Private Duty Nursing Services

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

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

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

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

## Skilled Nursing Facility Services

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

**No benefits are provided:**

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

## Surgical Services

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

- sterilization;
- therapeutic and elective 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 lymphedemas;
- Surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes as determined by Medical Mutual, subject to any appeal process. **Surgery to correct a deformity or birth defect for psychological reasons, where there is no functional impairment, is not covered.**

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

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

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

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

**Assistant at Surgery** - Another Physician's help to your surgeon in performing covered Surgery when a Hospital staff member, intern or resident is not available as 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 (head and neck muscle) disorders.

## Urgent Care Services

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

Examples of Urgent Care are:

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

## EXCLUSIONS

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

1. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
2. Not performed within the scope of the Provider's license.
3. Not Medically Necessary or do not meet Medical Mutual's policy, clinical coverage guidelines, or benefit policy guidelines.
4. Received from other than a 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 Medical Mutual.
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. For which benefits would have been payable under Part B of Medicare if a Covered Person had enrolled in Part B coverage. For the purposes of the calculation of benefits, if the Covered Person is eligible for, but has not enrolled in, Medicare Part B, Medical Mutual will calculate benefits as if he or she had enrolled. This provision only applies where Medicare is the primary payer under the law.
17. Received in a military facility for a military service related Condition.
18. For court-ordered testing or care unless Medically Necessary.
19. For Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss or weight loss Surgery), unless otherwise specified.
20. For weight loss Surgery and any repairs, revisions or modifications of such Surgery, including weight loss device removal, unless determined by Medical Mutual to be a Covered Service in accordance with Medical Mutual's corporate medical policy.
21. For Surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment.
22. For the removal of tattoos.
23. For dietary and/or nutritional counseling or training, unless otherwise specified or required by PPACA.
24. For Outpatient educational, vocational or training purposes, except as may be required by PPACA.
25. For treatment of learning disorders and intellectual disabilities, other than treatment necessary to evaluate or diagnose these Conditions.
26. For treatment of autism spectrum disorders.

27. For endoscopic screening procedures, other than colonoscopies and sigmoidoscopies required by PPACA.
28. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss or obesity.
29. For nutritional supplements taken orally.
30. For marital counseling.
31. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
32. For male Contraceptives and over-the-counter birth control without a prescription.
33. For reverse sterilization.
34. For devices, equipment and supplies used for the treatment of sexual dysfunction that is psychological or cosmetic in nature.
35. For treatment of infertility, including, but not limited to, artificial insemination, in vitro fertilization, Gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT).
36. 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.
37. 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.
38. For personal hygiene and convenience items.
39. 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.
40. 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).
41. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
42. For lost, stolen, or damaged medical supplies or durable medical equipment.
43. Immunizations and vaccines, including the administration of these services, that are billed by a Pharmacy. This does not apply to COVID-19 vaccine administration.
44. For massotherapy or massage therapy, except as directly performed by a licensed physical therapist, occupational therapist or chiropractor.
45. For hypnosis and acupuncture.
46. For blood which is available without charge. For Outpatient blood storage services.
47. For Prescription Drugs, except as specified.
48. For preventive services, unless otherwise specified and in accordance with state and federal law.
49. For specialized camps.
50. For water aerobics.
51. For After Hours Care.
52. For missed appointments, completion of claim forms or copies of medical records.
53. For an interpretation charge by a pathologist when the interpretation or result is already automatically provided by a machine-read or automated laboratory test.
54. For stand-by charges of a Physician.
55. For any Charges not documented in Provider records.
56. For fraudulent or misrepresented claims.
57. For charges for doing research with Providers not directly responsible for your care.
58. For services as the result of an injury or illness caused by or contributed to by engaging in an assault or felony.
59. 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.
60. 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.

61. 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](http://www.medmutual.com/member).

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

### Proof of Loss

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

Medical Mutual is not legally obligated to reimburse for Covered Services on behalf of the Plan unless written or electronically submitted proof that Covered Services have been given to you is received. Proof must be given within 90 days of your receiving Covered Services or as soon as is reasonably possible. Except in the absence of legal capacity, no proof can be submitted later than twenty-four (24) months 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 PPO 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, Medical Mutual will calculate its payment based upon the applicable Allowed Amount or Non-Contracting Amount. Please review the following descriptions for additional information.

### PPO Network and other Contracting Providers

Medical Mutual has agreements with Providers both inside and outside the PPO Network, both of which are referred to as Contracting Providers. While the highest level of benefits is provided when you obtain Covered Services from PPO Network Providers, both PPO 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 Medical Mutual 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 PPO Network Providers versus other Contracting Providers and Non-Contracting Providers.

## **Non-Contracting Providers**

If you choose to obtain services from a Non-Contracting Provider, your out-of-pocket expenses will likely be significantly higher than what you would pay by choosing a PPO Network Provider. Copayments, Deductibles and Coinsurance are usually higher when utilizing a Non-Contracting Provider, as shown on the Schedules of Benefits. Also, Medical Mutual 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.

As noted in the General Exclusions, a 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. 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 Medical Mutual 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, Medical Mutual pays for benefits in an amount equal to the greatest of the following:

1. The 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.

Any charges exceeding the Allowed Amount, Non-Contracting Amount or the amount payable for Emergency Services received from a Non-Contracting Provider described above will not apply toward any Deductible, Out-of-Pocket Maximum or benefit maximum accumulation.

## **Your Financial Responsibilities**

You are responsible for:

- Any Copayment, Deductible and Coinsurance amounts specified in the Schedule of Benefits. Copayments are generally required to be paid at the time of service. Some Providers can determine the amount due for your Deductible and Coinsurance from Medical Mutual and may require payment from you before providing their services.
- Non-Covered Charges.
- Billed Charges for all services and supplies after benefit maximums have been reached.
- Excess Charges for services and supplies rendered by Non-PPO Network and Non-Contracting Providers.
- 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, 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.

## **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 Medical Mutual's Negotiated Amounts.

## **Provider Status and Direction of Payment**

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

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

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

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

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

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

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



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

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

In some cases, Medical Mutual may determine that certain Covered Services can only be provided by a Non-PPO Network or Non-Contracting Provider. If Covered Services provided by a Non-PPO Network or Non-Contracting Provider are approved in advance by Medical Mutual, benefits will be provided as if the Covered Services were provided by a PPO Network Provider. However, 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-PPO Network or Non-Contracting Provider, your PPO Network Provider must provide Medical Mutual with:

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

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

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

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

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

## **Explanation of Benefits**

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

## **Time of Payment of Claims**

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

## **Foreign Travel**

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

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

## **Circumstances Beyond the Control of the Plan**

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

## **Review of Benefit Determinations**

### **Review of Benefit Determinations**

The Highway Patrol Retirement System does not make benefit determinations for any claims under the Plan. If you have questions or concerns regarding your health care coverage, the Highway Patrol Retirement System encourages you to contact Medical Mutual and, if appropriate, pursue the review of benefit determinations procedures cited in this section. The final decision on the determination of any claim or request for coverage is the sole and exclusive responsibility of Medical Mutual.

You are entitled to a review of benefit determinations if you have questions or do not agree with a determination made by Medical Mutual. A review of benefit determinations can apply whether you have a claim that was denied in part or in full or you received a notice of denial or reduced benefits associated with a service not yet performed.

To obtain a review, you or an authorized representative should submit a request in writing to the service center noted on your explanation of benefits (EOB) or notice of certification. Your request should include the group name (i.e., Highway Patrol Retirement System), your name, Highway Patrol Retirement System identification number, and other identifying information shown on the EOB or notice of certification, along with the issues and comments you would like to have considered. You may also review documents that were used to review your claim for which you are requesting a review of benefit determinations. Written request for review of benefit determinations must be mailed or delivered within 180 calendar days following receipt of your EOB or notice of certification. Ordinarily, you will receive notification of the final determination within 15 calendar days (preservice requests) or 30 calendar days (postservice claims) following Medical

Medical Mutual's receipt of your request. If special circumstances require an extension of time, you will be notified of such extension during the 15 or 30 calendar days following Medical Mutual's receipt of your request.

If your health would be jeopardized if the requested services were delayed, you may request an expedited review of benefit determinations. Criteria for expedited reviews include a delay that could:

- Place your health or the health of an unborn child in serious jeopardy;
- Cause serious impairment to bodily functions; or
- Cause serious dysfunction of any body organ or part.

Expedited determinations will be made within 72 hours of receipt of all required information.

If you have received preauthorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

A claim involving urgent care is any claim for Medical Care or treatment with respect to which the application of the time periods for making a nonurgent care determination could seriously jeopardize the life or health of the Person or the ability of the Person to regain maximum function, or, in the opinion of a Physician with knowledge of the Person's medical Condition, would subject the Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

### **External Review**

If the outcome of your request for benefit determinations upholds the original denial or reduction in coverage and you do not agree with this determination, you may request an external review.

An external review is a review by an independent Physician with appropriate expertise in the area pertaining to a denied claim or coverage request when the review of benefit determinations appeals process has been exhausted. The denial of the claim or request for coverage must have been based upon lack of medical necessity or the experimental or investigational nature of the proposed service or treatment.

You may, at your option, obtain external review of a claim denial or request for coverage for yourself or one of your dependents provided:

- You have exhausted the appeals process as outlined in the Review of Benefit Determinations section of this Medical Plan Description;
- The final determination resulted in denial of the claim or coverage request;
- The final denial was based upon a lack of medical necessity or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue exceeds \$500.

If the above requirements are met, you will receive written notice of your right to request an external review at the time the final decision on your appeal for review of benefit determinations has been rendered. An External Review Request Form will be included in the written notice provided by Medical Mutual. A written request must be submitted to Medical Mutual within 60 calendar days after you receive the final decision on your appeal for review of benefit determinations. You or an authorized representative acting on your behalf will be required to submit to Medical Mutual:

- An External Review Request Form (except under expedited review as described below);
- EOB, Notice of Payment or determination letter; and
- All other information you wish to be reviewed in support of your request.

The required information should be sent to:

Medical Mutual  
Member Appeals Unit  
P.O. Box 94580  
Cleveland, OH 44101-4580

Medical Mutual Enrollees may also fax their information to (216) 687-7990.

Medical Mutual will contact the organization that will conduct the external review. The external review organization will then select an independent Physician with appropriate expertise in the area at issue for the purpose of performing the

external review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the External Review Request Form, and must follow the contractual documents and coverage criteria governing the Plan.

The external review organization will generally notify you of the decision within 30 calendar days of Medical Mutual's receipt of a properly completed External Review Request Form. The notice will state whether the prior determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer will be binding except where Medical Mutual or Medical Mutual on behalf of the Plan can show reviewer conflict of interest, bias or fraud. In such cases, notice will be given to you and the matter will be promptly resubmitted for consideration by a different external reviewer.

An expedited external review is available when the treating Physician certifies on a separate Request for Expedited External Review Form (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30 calendar-day period) in receipt of the service or treatment would jeopardize the health of the Person or the ability of the Person to regain maximum function, or, in the opinion of a physician with knowledge of the Person's medical Condition, would subject the Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. An expedited external review will be decided within five calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending the information that you wish to be reviewed by the external review organization to Medical Mutual. Medical Mutual is responsible for the cost of sending the information to the external review organization and the professional fee for the external review.

For an individual to act on your behalf in connection with an external review, you will need to specifically consent to the representation by signing the appropriate line on the External Review Request Form.

You may obtain more information about the external review process by calling Medical Mutual.

## **Claim Review**

### **Consent to Release Medical Information - Denial of Coverage**

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

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

### **Right to Review Claims**

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

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

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

### **Physical Examination**

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

## Legal Actions

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

## Coordination of Benefits

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

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

### Definitions

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

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

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

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

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

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

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

#### Order Of Benefit Determination Rules

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

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

- However, if one parent's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
    - b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
    - c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
    - d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      - The **Plan** covering the **Custodial parent**;
      - The **Plan** covering the spouse of the **Custodial parent**;
      - The **Plan** covering the **non-custodial parent**; and then
      - The **Plan** covering the spouse of the **non-custodial parent**.
  3. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.
- c. Active employee or retired or laid-off employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.
  - d. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.
  - e. Longer or shorter length of coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.
  - f. If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

### Effect On The Benefits Of This Plan

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

2. If a Covered Person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

### **Right To Receive And Release Needed Information**

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

### **Facility of Payment**

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

### **Right of Recovery**

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

### **Coordination Disputes**

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

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

## **Changes In Benefits or Provisions**

The 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 Card Holder fails to make the required contributions.
- On the date a Covered Person insured as a spouse stops being an Eligible Dependent.

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

## COBRA

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, Eligible Dependents must apply for continuation coverage and pay the required premium before the deadline for payment. COBRA coverage can extend up to 36 months, depending on the particular "qualifying event" which gave rise to COBRA.

### Benefits After Termination of Coverage

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

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

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

### Rescission of Coverage

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

## HEARING SCHEDULE OF BENEFITS

Benefit Period	Calendar year
Dependent Age Limit	The end of the month of the 26th birthday

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

TYPE OF SERVICE	MAXIMUMS AND LIMITATIONS
Audiometric Examinations	One examination every 36 months
Conformity Evaluations	One examination every 36 months
Hearing Aids (Not all hearing aids are covered or are covered in full, and you may be subject to balance billing.)	One hearing aid per ear every 36 months \$1,000 maximum for hearing aid and batteries per ear every 36 months
Hearing Aid Evaluations	One evaluation every 36 months

COINSURANCE PAYMENTS	Professional Charges
TYPE OF SERVICE	For Covered Services received from a Contracting Hearing Coverage Provider, you pay the following, based on the Allowed Amount*
<b>COINSURANCE DUE</b>	
Audiometric Examinations	20%
Conformity Evaluations	20%
Hearing Aids (Not all hearing aids are covered or are covered in full, and you may be subject to balance billing.)	20%
Hearing Aid Evaluation Tests	20%

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

**If you request unusual services from a Hearing Coverage Provider, you must pay the full additional charge whether or not such services are expressly excluded from coverage.**

# HEARING SERVICES RIDER

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

## HEARING SERVICES

The following are Covered Services:

- **Audiometric Examinations**

This examination must be performed by:

- a Physician-Specialist; or
- an Audiologist.

- **Hearing aid evaluation tests.**

These tests must be performed by:

- a Physician-Specialist; or
- an Audiologist;

and may include the trial and testing of various makes and models of hearing aids to determine which will best compensate for the loss of hearing. This evaluation testing must be indicated by the most recent Audiometric Examination.

- **Hearing aids.** (Not all types of hearing aids are covered or are covered in full, and you may be subject to balance billing.)
- **Conformity evaluation.** This follow-up visit must be to the:
  - prescribing Physician-Specialist; or
  - Audiologist;

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

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

### Exclusions

In addition to the non-covered items listed in the "Exclusions" section of this Benefit Book, coverage is not provided for services and supplies:

1. For a hearing examination or materials ordered as a result of a hearing examination prior to your Effective Date.
2. For replacement of hearing aids that are lost or broken, unless at the time of such replacement, thirty-six (36) months have elapsed since you last received a hearing aid for which coverage was provided.
3. For ear molds and ear impressions.

## DEFINITIONS

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

**Audiologist** - any person who:

- has a master's or doctorate's degree in audiology or speech pathology from an accredited university; and
- has a Certificate of Clinical Competence in Audiology or an Equivalency Certificate from the American Speech and Hearing Association; and

- is qualified in the state in which the service is provided to conduct an Audiometric Examination and hearing aid evaluation test for the purposes of measuring hearing acuity and determining and prescribing the type of hearing aid that would best improve the Covered Person's loss of hearing acuity.

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

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

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

# Multi-Language Interpreter Services & Nondiscrimination Notice



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

## Spanish

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

## Chinese

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

## German

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

## Arabic

ملحوظة: إذا كنت 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

Dí baa akó nínizin: Dí saad bee yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, kojí' 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).

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**Civil Rights Coordinator**

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

**Email:** [CivilRightsCoordinator@MedMutual.com](mailto: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](http://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](http://hhs.gov/ocr/office/file/index.html)

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