

Vision Benefit Book

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

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VISION SCHEDULE OF BENEFITS

Benefit Period	Rolling 12 Months
Dependent Age Limit	The end of the month of the 26th birthday

The choice of a Provider is solely yours. Physicians and Other Professional Providers are designated as Managed Vision Care or Non-Managed Vision Care.

The amount of benefits you receive for Covered Services may vary depending upon the status of the Provider. To receive maximum benefits, Covered Services must be provided by a Managed Vision Care Provider. When Covered Services are provided by Non-Managed Vision Care Providers, your benefits may be lower. This Schedule of Benefits tells you how much Medical Mutual will provide for benefits for Covered Services provided by Managed Vision Care and Non-Managed Vision Care Providers.

The following are subject to a \$15 Copayment when received from a Managed Vision Care Provider:

- Contact Lens Examinations (1);
- Spectacle Examinations;
- Lenses; and
- Contact Lenses

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

Type of Service	Managed Vision Care Provider	Non-Managed Vision Care Provider
	Medical Mutual Pays the Following	
Spectacle or Contact Lens Examinations	One exam per 12 month period (2)	\$15 maximum per exam
Frames	One Frame per 12 month period (2) \$100 maximum per Frame	\$30 maximum per Frame
Lenses	One pair per 12 month period (plastic lenses only) (2) Single Vision Bifocals Trifocals Lenticular	Single Vision \$10 maximum per pair Bifocals \$20 maximum per pair Trifocals \$30 maximum per pair Lenticular \$40 maximum per pair
Contact Lenses	M e d i c a l l y \$200 maximum Necessary: per 12 month period (2)(3) Cosmetic: \$100 maximum per 12 month period (2)(3) Disposable: \$100 maximum per 12 month period (2)(3)	M e d i c a l l y \$75 maximum per Necessary: 12 month period (2)(3) Cosmetic: \$40 maximum per 12 month period (2)(3) Disposable: \$40 maximum per 12 month period (2)(3)

Notes

1. When obtaining a contact lens examination, you will also be responsible for payment of any amount over the cost of a spectacle examination.
2. Benefit frequency maximum specified applies to both Managed Vision Care and Non-Managed Vision Care services.
3. Benefits available for Lenses and Frames may be used for Contact Lenses in lieu of Lenses and Frames.

VISION BENEFIT BOOK

This Benefit Book describes the vision benefits available to you as a participant in the Self Funded Benefit Plan (the Plan) offered to you by your Employer (the Plan Sponsor). It is subject to the terms and conditions of the Plan Document. This is not a summary plan description or an Employee Retirement Income Security Act (ERISA) Plan Document by itself. However, it may be attached to or included with a document prepared by your Group that is called a summary plan description.

There is a Group Contract is between Medical Mutual and the Plan Sponsor.

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

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

The Plan Administrator shall have the exclusive right to interpret and apply the terms of this Benefit Book. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Medical Mutual and the Plan Sponsor, and such decisions shall be final and conclusive.

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

This Benefit Book should be read and re-read in its entirety. Many of the provisions of this Benefit Book are interrelated; therefore, reading just one or two provisions may not give you an accurate impression of your coverage.

Your Benefit Book may be modified by the attachment of Riders and/or amendments. Please read the provision described in these documents to determine the way in which provisions in this Benefit Book may have been changed.

Many words used in this Benefit Book have special meanings. These words will appear capitalized and are defined for you in the Definitions section. By reviewing these definitions, you will have a clearer understanding of your Benefit Book.

HOW TO USE YOUR BENEFIT BOOK

This Benefit Book describes your vision benefits. Please read it carefully.

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

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

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

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

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

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.

ELIGIBILITY

Applying for Coverage

Prior to receiving this Benefit Book, you applied for individual coverage or family coverage. For either coverage, you completed an enrollment form or Application. There may be occasions when the information on the enrollment form or Application is not enough. The Plan will then request the additional data needed to determine whether you are eligible.

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 Dependents

An Eligible Dependent is:

- the Card Holder's spouse;
- the Card Holder or spouse's unmarried children, stepchildren, children placed for adoption, 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 the Card Holder's spouse. To be considered Eligible Dependents, children's ages must fall within the age limit specified in the Schedule of Benefits, and they must receive over half of their support during the calendar year from the Card Holder unless coverage is being provided under court order.

Eligibility will continue past the age limit for Eligible Dependents who are unmarried and primarily dependent upon the Card Holder for support due to a physical handicap or mental retardation which renders them unable to work. This incapacity must have started before the age limit was reached and must be medically certified by a Physician. You must notify your Plan Sponsor 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.

Qualified Medical Child Support Order

In general, a Qualified Medical Child Support Order (QMCSO) is a court order that requires an eligible employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or paternity dispute. A QMCSO 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 any QMCSO as defined by ERISA section 609(a). The Group will promptly notify affected participants and alternate recipients if a QMCSO is received. The Group will notify these individuals of its procedures for determining whether medical child support orders are qualified; within a reasonable time after receipt of such order, the Group will determine whether the order is qualified and notify each affected participant and alternate recipient of its determination.

Once the dependent child is enrolled as an alternate recipient under a QMCSO, 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. The Effective Date is determined by the Plan Sponsor. No benefits will be provided for services, supplies or charges Incurred before your Effective Date.

Changes in Coverage

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

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

additional child. Coverage will continue for the adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

It is important to complete and submit your Application promptly as the date this new coverage begins will depend on when you apply.

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

Your Identification Card

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

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

VISION BENEFITS

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

The following are Covered Services:

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

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

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

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

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

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

EXCLUSIONS

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

1. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
2. Not performed within the scope of the Provider's license.
3. For Experimental or Investigational equipment, drugs, devices, services, supplies, tests, medical treatments or procedures.
4. For diagnostic services, drugs or medications not part of a vision examination.
5. For medical or surgical treatment.
6. That Medical Mutual determines are special or unusual; such as orthoptics, vision training and low vision aids.
7. For the replacement of Lenses or Frames except as specified in the Schedule of Benefits.
8. For Lenses which are not prescribed.
9. For dilation services received as part of a vision examination.
10. For safety glass and safety goggles.
11. For tints other than Number One or Two.
12. For tints with photosensitive or antireflective properties.
13. For progressive lenses.
14. For spectacle lens treatments or "add-ons", except for tints Number One or Two.
15. 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).
16. For a Condition occurring in the course of employment or for occupational injuries sustained by sole proprietors, if whole or partial benefits or compensation could be available under the laws of any governmental unit. This applies whether or not you claim such compensation or recover losses from a third party.
17. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
18. For which you have no legal obligation to pay in the absence of this or like coverage.
19. 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.
20. For an eye examination or materials ordered as a result of an eye examination prior to your Effective Date.
21. Incurred or received after you stop being a Covered Person.
22. Received from a member of your Immediate Family.
23. For which payment was made or would have been made under Medicare Part B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
24. For a Condition that occurs as a result of any act of war, declared or undeclared.
25. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
26. Received in a military facility for a military service related Condition.
27. For fraudulent or misrepresented claims.
28. For non-Covered Services or services specifically excluded in the text of this Benefit Book.

GENERAL PROVISIONS

How to Apply for Benefits

Notice of Claim; Claim Forms

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

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

Proof of Loss

Proof of loss is a claim for payment of vision services which has been submitted to Medical Mutual for processing with sufficient documentation to determine whether Covered Services have been provided to you. Medical Mutual must receive a completed claim with the correct information.

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

GENERAL PROVISIONS

How Claims are Paid

Coinsurance

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

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 Medical Mutual on behalf of the Plan. Please refer to the Schedule of Benefits for specific Copayment amounts.

Schedule of Benefits

The Schedule of Benefits shows the maximum benefits Medical Mutual will pay on behalf of the Plan for Covered Charges. You may also be responsible for Billed Charges less the amount specified in the Schedule of Benefits.

Your Financial Responsibilities

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

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

Provider Status and Direction of Payment

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

Some of Medical Mutual's contracts with Providers allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual and Medical Mutual will retain any payments resulting therefrom; however, Coinsurance and benefit maximums will be calculated as described in this Benefit Book.

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

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

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

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

Any reference to Providers as Managed Vision Care, Non-Managed Vision Care, Participating or Non-Participating is not a statement about their abilities.

Explanation of Benefits

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

Time of Payment of Claims

Benefits will be provided under this Benefit Book within 30 days after receipt of a completed claim. To have a payment or denial related to a claim reviewed, you must send a written request to Medical Mutual within 180 days of the claim determination.

Filing a Complaint

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

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

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

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

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

Benefit Determination for Claims

Claims Involving Urgent Care

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

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

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

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

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

Concurrent Care Claims

If Medical Mutual has approved an ongoing course of treatment to be provided over a period of time or for a number of treatments, any reduction or termination by Medical Mutual of such course of treatment before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination).

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

Pre-Service Claims

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

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

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

Post-Service Claims

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

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

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

Adverse Benefit Determination Notices

You will receive notice of a benefit determination, orally as allowed, or in writing. All notices of an adverse benefit determination will include the following:

- the specific reason(s) for the adverse benefit determination;
- reference to the specific plan provision(s) on which the adverse benefit determination is based;
- sufficient information to identify the claim or health care service involved, including the date of services, the health care provider, and the claim amount, if applicable;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of Medical Mutual's appeal procedures and applicable timeframes, including the expedited appeal process, if applicable;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the adverse benefit determination was based on Medical Necessity, Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

Filing an Appeal

If you are not satisfied with a benefit determination or a Medical Necessity determination, then you may file an appeal.

To file an appeal, contact the telephone number or address on your current identification card or Explanation of Benefits and provide the following information: Card Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, documents, dental X-rays or photographs you would like considered in the appeal.

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

Mandatory Internal Appeal

The Plan offers you a mandatory internal appeal. You must complete this mandatory internal appeal before any additional action is taken.

Mandatory internal appeals must be filed within 180 days from your receipt of a notice of adverse benefit determination. All requests for appeal may be made by submitting an electronic form or in writing as described in the Filing an Appeal section above.

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law for this plan. The internal appeal process is a review of your appeal by an appeals specialist, a Physician consultant and/or other licensed health care professional. The review of an appeal will take into account all comments, documents, medical

records and other information submitted by you and the Provider relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination.

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

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

The appeal procedures are as follows:

Appeal of a Claim Involving Urgent Care

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

Pre-Service Claim Appeal

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

Post Service Claim Appeal

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

All notices of a final adverse benefit determination after an appeal will include the following:

- the specific reason(s) for the adverse benefit determination;
- reference to the specific plan provision(s) on which the adverse benefit determination is based;
- sufficient information to identify the claim or health care service involved, including the date of services, the health care provider, and the claim amount (if applicable);
- statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- if the adverse benefit determination was based on a Medical Necessity, Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan

to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request; and

- a description of applicable appeal procedures.

Claim Review

Consent to Release Medical Information - Denial of Coverage

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

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, precertification 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 spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
 2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
 - b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
 - c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
 - d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The **Plan** covering the **Custodial parent**;
 - The **Plan** covering the spouse of the **Custodial parent**;
 - The **Plan** covering the **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 first attempt to resolve the problem by contacting Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>.

Right of Subrogation and Reimbursement

Subrogation

The Plan reserves the right of subrogation. This means that, to the extent the Plan provides or pays benefits or expenses for Covered Services, the Plan assumes your legal rights to recover the value of those benefits or expenses from any person, entity, organization or insurer, including your own insurer and any under insured or uninsured coverage, that may be legally obligated to pay you for the value of those benefits or expenses. The amount of the Plan's subrogation

rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of subrogation shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of subrogation for the total amount the Plan paid for Covered Services is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. Furthermore, the Plan shall not bear any costs, expenses or attorney fees Incurred by your, your beneficiary or personal representative in the prosecution of any claim for recovery. This provision is intended to and does reject and supersede the "make-whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of subrogation.

You, your beneficiary or personal representative shall execute and deliver any documents as may be required by the Plan and do whatever else is necessary for the Plan to protect and exercise its subrogation rights, and you or such persons shall do nothing to prejudice the Plan's right hereunder. If you, your beneficiary or personal representative does prejudice the Plan's rights hereunder, such prejudicial action, among other things, shall bar you or such persons from receiving benefits under the Plan.

Reimbursement

The Plan also reserves the right of reimbursement. This means that, to the extent the Plan provides or pays benefits or expenses for Covered Services, you must repay the Plan any amounts recovered by suit, claim, settlement or otherwise, from any third party or his insurer and any under insured or uninsured coverage, as well as from any other person, entity, organization or insurer, including your own insurer, from which you receive payments (even if such payments are not designated as payments of medical expenses). The amount of the Plan's reimbursement rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of reimbursement shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of reimbursement for the total amount the Plan paid for Covered Services is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. Furthermore, the Plan shall not bear any costs, expenses or attorney fees Incurred by you, your beneficiary or personal representative in the prosecution of any claim for recovery. This provision is intended to and does reject and supersede the "make whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of reimbursement.

You, your beneficiary or personal representative shall execute and deliver any documents as may be required by the Plan and do whatever else is necessary for the Plan to protect and exercise its reimbursement rights, and you or such persons shall do nothing to prejudice the Plan's right hereunder. If you, your beneficiary or personal representative does prejudice the Plan's rights hereunder, such prejudicial action, among other things, shall bar you or such persons from receiving benefits under the Plan.

Your Duties

- You must provide the Plan or its designee any information requested by the Plan or its designee within five (5) days of the request.
- You must notify the Plan or its designee promptly of how, when and where an accident or incident resulting in personal injury to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan or its designee in the investigation, settlement and protection of the Plan's rights.
- You must send the Plan or its designee copies of any police report, notices or other papers received in connection with the accident or incident resulting in personal injury to you.
- You must not settle or compromise any claims unless the Plan or its designee is notified in writing at least thirty (30) days before such settlement or compromise and the Plan or its designee agrees to it in writing.

Discretionary Authority

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.

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 under the terms and conditions, as described in this Benefit Book, stops:

- On the date under the terms and conditions of the Plan, as described in this Benefit Book, a Covered Person stops being an Eligible Dependent or if coverage is extended by your Group for Full-time Student status, on the date the Full-time Student status ends. You are responsible for notifying the Group immediately of any change to the eligibility status of a Full-time Student and/or Eligible Dependent.
- At the end of the month in which a Card Holder becomes ineligible.
- On the day a final decree of 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 materially misrepresents a material fact provided to the Group or Medical Mutual or commits fraud or forgery.

Certificate of Creditable Coverage

If any Covered Person's coverage would end and the Agreement is still in effect, you and your covered Eligible Dependents will receive a certificate of Creditable Coverage that shows your period of coverage under the Plan.

Federal Continuation Provisions - COBRA

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

When You Are Eligible for COBRA

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

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

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

In the case of an active employee, or Eligible Dependent of a Card Holder, covered by the Plan, he or she has the right to continuation coverage if group coverage under the Plan is lost for any of the following reasons:

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

Notice Requirements

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

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

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

How Long COBRA Coverage Will Continue

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

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

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

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

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

Additional Information

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

You do not have to provide proof of insurability to obtain continuation coverage. However, under COBRA, you will have to pay all of the premium (both employer and employee portion) for your continuation coverage, plus a 2% administrative fee. You will have an initial grace period of 45 days (starting with the date you choose continuation coverage) to pay any premiums then due; after that initial 45-day grace period, you will have a grace period of 30 days to pay any subsequent premiums. (During the last 180 days of your continuation coverage period, you must be allowed to enroll in an individual conversion plan if one is provided by the Group. However, conversion coverage is not available if the Agreement terminates or the Group goes out of business. Call the Group during your last 180 days of COBRA for information on conversion).

It is your Group's responsibility to advise you of your COBRA rights and to provide you with the required documents to complete upon the qualifying event.

Continuation of Coverage During Military Service

If you go on active duty in the U.S. armed forces, you will cease to be covered under the regular group health plan as of the end of the month in which you enter active military service. However, you have the following rights to continue coverage:

1. If the military leave period is less than 31 days, you have the right to continue coverage for yourself and dependents who were covered under the group plan for up to 31 days, at a cost of not more than the cost for a similarly situated active employee.
2. If the military leave period is more than 31 days, you are entitled to continue coverage for yourself and your dependents who were covered under the group plan under the United States Employment and Reemployment Rights Act (USERRA). You may continue coverage under this Act for up to 24 months at 102% of the cost of the coverage. This continuation right is concurrent with any right to continue coverage under COBRA. USERRA coverage will end earlier if one of the following events takes place:
 - a. A premium payment is not made within the required time;
 - b. You fail to report to work or to apply for reemployment within the time required under USERRA following the completion of your service in the uniformed services; or
 - c. You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

DEFINITIONS

Benefit Book - this document.

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

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

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

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

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

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

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

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.

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 the Vision Benefits section of this Benefit Book for which the Plan will provide benefits, as listed in the Schedule of Benefits.

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

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

Excess Charges - the amount of Billed Charges less Non-Covered Charges in excess of the Traditional Amount for a Non-Participating Physician or Other Professional Provider.

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

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

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

Frame - standard eyeglasses excluding the Lenses.

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

Immediate Family - the 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.

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

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

Managed Vision Care Provider - a Physician or Other Professional Provider which is included in a limited panel of Providers as designated by Medical Mutual as a Managed Vision Care Provider to perform routine vision services and for which the greatest benefit will be payable when one of these Providers is used.

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

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

Contact Lenses are considered Medically Necessary when:

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

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

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

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

Non-Managed Vision Care Provider - a Physician or Other Professional Provider which is not designated by Medical Mutual as a Managed Vision Care Provider.

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

Optometrist - a person licensed to practice optometry.

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

- Optometrist; and
- Optician.

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

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

Provider - Physician or Other Professional Provider.

Surgery -

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

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

- the actual amount billed by a Provider for a given service

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

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, éi ná hóló, koji' 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).

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

Order Number: Z8188-MCA R4/19
Dept of Ins. Filing Number: Z8188-MCA R9/16

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator

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

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201-0004
- By phone at:
1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

