SHELLY & SANDS, INC.

Group Number
898472-101, 102, 103, 104, 105, 106, 107, 108, 110

PPO Network Comprehensive Major Medical Health Care Benefit Book

Prescription Drug Rider

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

SUMMARY PLAN DESCRIPTION

THE INFORMATION FOUND IN THE SUMMARY PLAN DESCRIPTION IS NOT A PART OF YOUR BENEFIT BOOK

Introduction

Shelly & Sands (collectively referred to herein as the "Employers" and individually as an "Employer") maintain the Shelly & Sands Employee Benefits Plan ("the Plan") for the exclusive benefit of their eligible employees and their eligible dependents. The Plan provides medical benefits, (for Buckingham only) and under self-insured arrangements, and eligible employees are permitted, to the extent provided by law, to pay for their share of the premiums for such benefits on a pre-tax basis, as provided under Section 125 of the Internal Revenue Code of 1986, through the Shelly & Sands Cafeteria Benefits Plan maintained by the Employers (the "Cafeteria Plan").

Plan benefits, including information about eligibility, are summarized in the Certificate of Insurance booklet describing the benefits provided under the Plan (the "Plan Booklets"), copies of which are available from your Human Resources Department, free of charge. The Certificate of Insurance, together with this document constitute the Summary Plan Description required by the federal law known as the Employee Retirement Income and Security Act ("ERISA"). Capitalized terms not otherwise defined in this document are defined in the Certificate of Coverage Booklets.

SPECIFIC PLAN INFORMATION:

Plan Name:	Shelly & Sands, Inc. Welfare Benefit Plan
Type of Plan:	A welfare benefit plan subject to provisions of ERISA
Plan Year:	June 1st through May 31st
Plan Number:	501
Employer / Plan Sponsor:	Shelly & Sands, Inc. PO Box 1585 Zanesville, OH 43702 (740) 453-0721
Plan Funding and Type of Administration:	self-funded
Plan Sponsor's Employer Identification Number:	34-4351261
Plan Administrator:	Shelly & Sands
Named Fiduciary:	Michael Cline
Agent for Service of Legal Process:	Shelly & Sands
Important Disclaimer:	Plan benefits are provided under group contracts and/or policies issued by Medical Mutual. If the terms of this summary document conflict with the terms of this Plan, the terms of this Plan will control, unless superseded by applicable law.

Eligibility

To determine whether you, your spouse and dependents are eligible to participate in the benefits provided under the Plan, please read the eligibility information contained in the Certificates of Coverage Booklets provided to you by your Employer with respect to each of the benefits provided under the Plan.

The Plan will extend medical benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children. Also eligible for medical benefits is any child covered under a Qualified Medical Child Support Order (QMCSO) as defined by applicable law and determined by the Employers under their QMCSO procedures, a copy of which is available from the Human Resources Department, free of charge.

Coverage with respect to any of the benefits provided under the Plan will terminate if you no longer meet the eligibility requirements applicable to such benefits. Coverage with respect any of the benefits provided under the Plan may also terminate if you fail to pay your share of the premium applicable to such benefit, if your hours drop below any required eligibility threshold applicable to such benefit, or if you submit false claims, etc. with respect to such benefit. (See the Certificate of Coverage Booklet applicable to each of the benefits provided under the Plan for more information.) Coverage for your spouse and dependents with respect to a benefit provided under the Plan stops when your coverage stops with respect to such benefit. Their coverage with respect to a benefit provided under the Plan will also stop for other reasons specified in the Certificate of Coverage or Plan Booklet applicable to such benefit.

Special Situations, Extension of Coverage

Family and Medical Leave Act

If you qualify for an approved family or medical leave of absence (as defined in the Family and Medical Leave Act ("FMLA")), eligibility for some or all of the benefits provided under the Plan may continue for the duration of the leave if required contributions for such benefits are paid toward the cost of the coverage. Your Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your Employer will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your Employer has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA.

If coverage with respect to a benefit provided under the Plan is terminated for failure to make payments while you are on an approved family or medical leave of absence, coverage with respect to such benefit for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible for such benefit under the Plan. Any waiting period for pre-existing conditions or other waiting periods applicable to such benefit will not apply. However, all accumulated annual and lifetime maximums applicable to such benefit will apply.

If you do not return to work at the end of an FMLA leave, you may be entitled to elect COBRA Continuation Coverage with respect to certain of the benefits provided under the Plan, such as dental and vision benefits, even if you were not covered under the Plan with respect to such benefits during the leave. Coverage continued under this provision is in addition to coverage described below under the section entitled "COBRA Continuation Coverage."

The Plan intends to comply with all existing FMLA regulations. If for some reason the information presented differs from the FMLA regulations, the Plan Administrator reserves the right to administer the Plan in accordance with the FMLA regulations.

Military Leave Coverage

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") establishes requirements that employers must meet for certain employees who are involved in the uniformed services.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);
- The commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty training;
- Inactive duty training;

- Full-time National Guard duty;
- A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;
- A period for which you are absent from your job for the purpose of performing certain funereal honors duty; and
- Certain service by intermittent disaster response appointees of the National Disaster Medical System ("NDMS").

If you were covered with respect to a benefit provided under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage with respect to such benefit under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage with respect to such benefit during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

1. You fail to make a premium payment within the required time;
2. You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
3. You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage of such benefit. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "COBRA Continuation Coverage."

If your coverage with respect to a benefit provided under the Plan terminated because of your Service in the Uniformed Services, your coverage with respect to such benefit will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under this Plan with respect to a benefit is reinstated, all of the Plan's provisions and limitations applicable to such benefit will apply to the extent that they would have applied if you had not taken military leave and your coverage with respect to such benefit had been continuous. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact the Human Resource Department.)

The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the regulations promulgated under USERRA, the Plan Administrator reserves the right to administer the Plan in accordance with USERRA and the regulations promulgated thereunder.

COBRA Continuation Coverage

COBRA Continuation Coverage is a continuation of Plan coverage with respect to medical, vision and dental benefits ("COBRA-Eligible Benefits") when coverage under the Plan with respect to such benefits would otherwise end because of a life event known as a "qualifying event." The following are qualifying events with respect to COBRA-Eligible Benefits:

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and/or your eligible dependents;
- A reduction in your hours. Coverage may continue for you and/or your eligible dependents;
- Your death. Coverage may continue for your eligible dependents;
- Your divorce or legal separation. Coverage may continue for your eligible dependents;
- Your becoming entitled to Medicare. Coverage may continue for your eligible dependents; and
- Your covered dependent child's ceasing to be a dependent child under the Plan. Coverage may continue for that dependent.

Note: To choose this continuation coverage with respect to a COBRA-Eligible Benefit, an individual must be covered under the Plan with respect to such benefit on the day before the qualifying event. In addition, your newborn child or child placed for adoption with you during a period of continuation coverage will remain eligible for continuation coverage for the remaining period of coverage even if you and/or your spouse terminate continuation coverage following the child's birth or placement for adoption.

Notification Requirements

Under the law, you or the applicable dependent has the responsibility to inform the Plan Administrator, in writing, within 60 days of a divorce or legal separation or of a child losing dependent status under the Plan. Failure to provide this written notification within 60 days will result in the loss of continuation coverage rights.

Your Employer has the responsibility to notify the Plan Administrator of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event.

Subject to the Plan Administrator being informed in a timely manner of the qualifying events described in the above paragraphs, the Plan Administrator will promptly notify you and other qualifying individual(s) of their continuation coverage rights with respect to COBRA-Eligible Benefits. You and any applicable dependents must elect continuation coverage within 60 days after Plan coverage would otherwise end, or, if later, within 60 days of the notice of continuation coverage rights. Failure to elect continuation coverage within this 60-day period will result in loss of continuation coverage rights with respect to COBRA-Eligible Benefits.

Notice of Unavailability of Continuation Coverage

If the Plan Administrator receives a notice of a qualifying event from you or your dependent and determines that either you or your dependent is not entitled to continuation coverage with respect to any or all of the COBRA-Eligible Benefits, the Plan Administrator will provide an explanation as to why you or your dependent is not entitled to continuation coverage. This notice will be provided within the same time frame that the Plan Administrator would have provided the notice of right to elect continuation coverage.

Maximum Period of Continuation Coverage

The maximum period of continuation coverage is 36 months from the date of the qualifying event, unless the qualifying event is your termination of employment or reduction in hours. In that case, the maximum period of continuation coverage is generally 18 months from the date of the qualifying event.

However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled eligible dependents who are also entitled to continuation coverage may be extended to 29 months provided the qualifying individual or dependent, if applicable, notifies the Plan Administrator in writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of disability.

If a second qualifying event occurs (for example, your death or divorce) during the 18- or 29-month coverage period resulting from your termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is your spouse or dependent child whose qualifying event was the termination or reduction in hours of your employment and you became entitled to Medicare within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of continuation coverage is the longer of 36 months from the date of your Medicare entitlement or their otherwise applicable maximum period of coverage.

Cost of Continuation Coverage

The cost of continuation coverage is determined by the Plan Administrator and is paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102 percent of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150 percent of the Plan's cost of coverage.

Premium payments for continuation coverage for you or your eligible dependent's "initial premium month(s)" are due by the 45th day after electing continuation coverage. The "initial premium month(s)" are any month that ends on or before the 45th day after you or the qualifying individual elect continuation coverage. All other premiums are due on the first of the month for which coverage is sought, subject to a 30-day grace period. Premium rates are established by the Plan Administrator and may change when necessary due to Plan modifications. The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

1. The date the maximum continuation coverage period expires;
2. The date your Employer no longer offers the COBRA-Eligible Benefit to any of its employees;
3. The first day for which timely payment is not made to the Plan;

4. The date the qualifying individual becomes covered by another group health plan. However, if the new plan contains an exclusion or limitation for a pre-existing condition of the qualifying individual, continuation coverage will end as of the date the exclusion or limitation no longer applies;
5. The date the qualifying individual becomes entitled to coverage under Medicare; and
6. The first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.

Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a pre-existing condition exclusion. In order to be eligible to apply for such coverage from a carrier after ceasing participation in the Plan, you or your eligible dependents must elect continuation coverage under the Plan, continue through the maximum continuation coverage period (18, 29, or 36 months, as applicable), and then apply for coverage with the individual insurance carrier before a 63 day lapse in coverage. For more information about your right to such individual insurance coverage, contact an independent insurance agent or your state insurance commissioner.

Notice of Termination Before Maximum Period of COBRA Coverage Expires

If continuation coverage for a qualifying individual terminates before the expiration of the maximum period of continuation coverage, the Plan Administrator will provide notice to the individual of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the Plan Administrator's determination regarding termination of the continuation coverage.

The Plan intends to comply with all applicable laws regarding COBRA Continuation Coverage. If for some reason the information presented in this Plan differs from COBRA and the regulations promulgated thereunder, the Plan Administrator reserves the right to administer the Plan in accordance with COBRA and the regulations promulgated thereunder.

Summary of Plan Benefits

The Plan provides eligible employees and their eligible dependents with certain welfare benefits including health benefits. Medical plan benefits provided under the Plan to employees of Shelly & Sands are self-insured and are paid from the general assets of Shelly & Sands.

The Plan, through self-insurance, provides benefits in accordance with the applicable requirements of federal laws, such as Employee Retirement Income Security Act ("ERISA"), Consolidated Omnibus Budget Reconciliation Act ("COBRA"), Health Insurance Portability Accountability Act ("HIPAA"), Newborns' and Mothers' Health Protection Act ("NMHPA"), Mental Health Parity Act ("MHPA"), and the Women's Health and Cancer Rights Act ("WHCRA").

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them.

Claims for benefits under the Plan are submitted to:

Medical Mutual
P.O. Box 6018
Cleveland, Ohio 44101-4580

The above-named administrator, not the Employer, is responsible for paying the benefits which it administers. The administrator of the benefits provided under the Plan is also responsible for determining eligibility for and the amount of any benefits payable under the Plan and prescribing claims procedures and forms to be followed to receive the Plan benefits it provides. The administrator also has the discretionary authority to require participants to furnish it with such information as it determines is necessary for the proper administration of claims for the Plan benefits it provides.

Claims and Appeals

Each administrator and insurer of benefits provided under the Plan is responsible for evaluating all benefit claims under the Plan with respect to the benefits it administers or provides. Each administrator or insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. If your claim is denied, you may appeal to the administrator or insurer that provides the benefit for a review of the denied claim and such administrator or insurer will decide your appeal in accordance with its reasonable procedures, as required by ERISA. See the Certificates of Coverage

and Plan Booklet applicable to each of the benefits provided under the Plan for complete details regarding claims and appeals procedures.

Amendment or Termination of the Plan

The Employer has the right to amend or terminate the Plan at any time. You have no vested or permanent rights or benefits under the Plan. Plan benefits will typically change from year-to-year and you should examine the Certificates of Insurance Booklets provided to you each year to determine the benefits of the Plan.

No Contract of Employment

The Plan is not intended to, and does not, either directly or indirectly, constitute any form of employment contract or other employment arrangement between you and your Employer.

Other Materials

The Certificate of Coverage Plan Booklets is part of this Summary Plan Description. Please refer to Certificates of Coverage and Plan Booklets for other important provisions regarding your participation in the Plan.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan with respect to a COBRA-Eligible Benefit as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another group health plan.

You should be provided a certificate of creditable coverage, free of charge, from a group health plan or a health insurance issuer when you lose coverage under a group health plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Use With Grandfathered Group PPO, POS, HMO and Indemnity Plans

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

AMENDMENT

This Amendment amends your health benefit Plan (Plan), and becomes a part of your Plan as of the first day of the Plan's first Plan year on or after September 23, 2010, the Effective Date. Please place this Amendment with your certificate for future reference.

On the Effective Date of this Amendment, certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010 (PPACA).

Regardless of the terms and conditions of any other provisions of your Plan, this Amendment will control.

Grandfathered Health Plan Disclosure

Medical Mutual believes this Plan is a "grandfathered health Plan" under the PPACA. As permitted by PPACA, a grandfathered health Plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health Plan means that your Plan may not include certain consumer protections of PPACA that apply to other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health Plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health Plan and what might cause a Plan to change from grandfathered health Plan status can be directed to your group official. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health Plans.

The following Definition is added to your Plan:

"Essential Health Benefits" is 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. Your Plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your Plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this Amendment.

Lifetime Dollar Limits

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan's terms, and that Plan is still in effect, you should have received a notice that the lifetime dollar limit no longer applies and an opportunity to enroll or be reinstated under your Plan. Covered Persons who are eligible for this enrollment opportunity are treated as special enrollees.

Annual Dollar Limits

Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. Your Plan may include other benefits not defined as Essential Health Benefits, and those other benefits may have annual dollar limits.

The dollar amount of any lifetime limit that was in effect as of March 23, 2010, is your Plan's benefit period maximum for Essential Health Benefits, provided it is no less than $750,000.

If your Plan has annual dollar limits on Essential Health Benefits, they are subject to the following:

For a Plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit can be no less than $750,000.

For a Plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit can be no less than $1.25 million.

For a Plan year beginning on or after September 23, 2012, but before December 31, 2013, the limit can be no less than $2 million.

For a Plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan.

Any other annual dollar limits on Essential Health Benefits that may have existed are deleted.

Rescission of Coverage

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. 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 can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer. 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. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

Dependent Coverage (for Plans that make dependent coverage available)

Federal Law

This Plan will cover your married or unmarried child as defined in the Eligibility section of this Plan until your child reaches age 26, unless your child is eligible to enroll in an employer sponsored health

plan, other than a group health plan of a parent. For Plan years beginning after January 1, 2014, this Plan will cover your child up to age 26 even if your child has employer sponsored coverage available.

Ohio Law (does not apply to self-funded plans governed by ERISA)

Effective on the Plan's next renewal date on or after July 1, 2010 (unless an earlier effective date was requested by the Plan):

At the option of the Certificate Holder and at the Certificate Holder's expense, coverage for an Eligible Dependent child can be provided up to age 28. Subject to all other terms and conditions of the Certificate, coverage can be provided if the Eligible Dependent child is:

- not married;
- the natural child, stepchild or adopted child of the Certificate Holder or the Certificate Holder's spouse;
- a resident of Ohio;
- if not an Ohio resident, a Full-time Student at an accredited public or private institution of higher education;
- not employed by an employer that offers any health benefit Plan under which the child is eligible for coverage; and
- not eligible for coverage under Medicaid or Medicare.

No Preexisting Condition Limitations for Covered Persons under age 19

Any Preexisting Condition Limitations described in the Schedule of Benefits of your Plan do not apply to Covered Persons who are under 19 years of age. With respect to Covered Persons who are under 19 years of age, your Plan covers any condition that may have been previously excluded by name or specific description as a pre-existing condition. This also means a Covered Person under the age of 19 cannot be excluded from the Plan if the exclusion is based on a preexisting condition.

This Amendment takes effect on the first day of the Plan's first Plan year on or after September 23, 2010. This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

IN WITNESS WHEREOF:

Medical Mutual of Ohio

Rick Chiricosta
President and CEO

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL SCHEDULE OF BENEFITS

Benefit Period	Calendar year
PPO Network Deductible per Benefit Period	$300 single / $600 family
Non-PPO Network Deductible per Benefit Period	$600 single / $1,200 family
Dependent Age Limit	The end of the month of the 26th birthday
Coinsurance Limit	$2,200 single / $4,400 family
Non-PPO Network Coinsurance Limit	$4,000 single / $8,000 family

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

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

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

It is important that you understand how the Claims Administrator, 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.

Preexisting Condition Exclusion Period

This provision will not apply to Card Holders and Eligible Dependents who were covered on the date the Group originally entered into its Agreement with Medical Mutual and who were not subject to a Preexisting Condition exclusion at that time.

Preexisting Condition exclusions will be determined by the Plan provisions in effect on your Enrollment Date.

A Preexisting Condition is a Condition for which you Incurred medical expenses, received medical treatment, used Prescription Drugs or were advised by a Physician or Other Professional Provider to receive treatment prior to your Enrollment Date. Your Enrollment Date is your Effective Date or, if earlier, the first day of your waiting period for enrollment. Pregnancy or any Condition related to pregnancy is not considered a Preexisting Condition. Genetic information is not considered a Preexisting Condition in the absence of a diagnosis of the Condition related to such information.

If a Preexisting Condition existed at any time during the three month period immediately preceding your Enrollment Date, the Plan will provide benefits for the Preexisting Condition for Covered Services Incurred after 12 months following your Enrollment Date.

If you had other health care coverage prior to your Enrollment Date, and you did not experience a Significant Break in Coverage, your prior coverage will be credited toward the 12 month exclusion period and will reduce the Preexisting Condition Exclusion Period. A Significant Break in Coverage is a period of 63 consecutive days during which you did not have any other health care coverage, except that waiting periods are carved out. The standard method, which does not consider specific benefits, is used to determine creditable coverage.

BENEFIT PERIOD MAXIMUMS PER COVERED PERSON	
Home Health Care Services	40 days
Inpatient Physical Medicine and Rehabilitation Services and Skilled Nursing Facility Services	60 days (combined)
Medical Nutrition Therapy Services	Three visits
Routine Mammogram Services	One mammogram; limited to 130% of the Medicare reimbursement amount; the maximum reimbursement amount applies only to Covered Services received inside the state of Ohio, as mandated by the state of Ohio.
Routine PAP Tests	One test
Routine Vision Examinations	One examination

MAXIMUM BENEFIT PAYABLE PER TRANSPLANT PER COVERED PERSON	
For patient transportation	$10,000

COINSURANCE PAYMENTS	Institutional and Professional Charges	Institutional and Professional Charges
TYPE OF SERVICE	**For Covered Services received from a PPO Network Provider you pay the following**	**For Covered Services received from a Non-PPO Network or Non-Contracting Provider you pay the following**
EMERGENCY SERVICES		
Emergency - Emergency Room - the Institutional charge for use of the Emergency Room	$100 Copayment, waived if admitted, then 0% of Lesser Amount	$100 Copayment, waived if admitted, then 0% of Lesser Amount or Covered Charges
Emergency Services - all other related Institutional and Emergency Room Physician's charges	0% of Lesser Amount, not subject to Deductible	0% of Lesser Amount or Covered Charges, not subject to Deductible
Non-Emergency - Emergency Room - the Institutional charge for use of the Emergency Room	$100 Copayment, waived if admitted, then 0% of Lesser Amount	$100 Copayment, waived if admitted, then 40% of Lesser Amount or Covered Charges
Non-Emergency Services - Emergency Room Physician's charges	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
INPATIENT SERVICES		
Semi-Private Room and Board	20% of Lesser Amount after Deductible	40% of Lesser Amount or Covered Charges after Deductible
MENTAL HEALTH CARE, DRUG ABUSE AND ALCOHOLISM SERVICES		
Mental Health Care, Drug Abuse and Alcoholism Services	Any applicable Deductible, Coinsurance or Copayment corresponds to the type of service received and is payable on the same basis as any other illness (e.g., emergency room visits for Mental Illness, Drug Abuse and Alcoholism will be paid according to the Emergency Services section above).	
PHYSICIAN/OFFICE SERVICES		
Immunizations	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Medically Necessary Office Visits (1)	$20 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
Medically Necessary Office Visits, received from a Specialist	$40 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
Urgent Care Provider Office Visits	$35 Copayment, then 0% of Lesser Amount	40% of Lesser Amount or Covered Charges after Deductible
ROUTINE, PREVENTIVE AND WELLNESS SERVICES		
Child Health Supervision Services - for Covered Persons up to age 21	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Routine Laboratory Services, X-Rays and Medical Testing	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Routine Mammogram Services	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Routine Outpatient Endoscopic Procedures: Colonoscopy, Sigmoidoscopy, Anoscopy and Proctosigmoidoscopy only (3)	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Routine PAP Tests	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Routine Physical Examinations - for Covered Persons 21 years of age and older	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Routine Vision Examinations	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
SURGICAL SERVICES		
Inpatient Surgery	20% of Lesser Amount after Deductible	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Anesthesia and Assistant Surgeon Services performed in a Physician's office	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Surgical Services performed in a Physician's office (1)	$20 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Surgical Services performed in a Physician's office received from a Specialist	$40 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
All Other Outpatient Surgical Services	20% of Lesser Amount after Deductible	40% of Lesser Amount or Covered Charges after Deductible

COINSURANCE PAYMENTS	Institutional and Professional Charges	Institutional and Professional Charges
TYPE OF SERVICE	**For Covered Services received from a PPO Network Provider you pay the following**	**For Covered Services received from a Non-PPO Network or Non-Contracting Provider you pay the following**
OTHER SERVICES		
Chiropractic Visits	$40 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
Contraceptive Services - Injectable Contraceptives (including administration) received in a Physician's office	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Hospice Services	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Organ Transplant Services	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Allergy Testing	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Allergy Treatments (1)	$20 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Allergy Treatments received from a Specialist	$40 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Cardiac Rehabilitation Services	$40 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Diagnostic Laboratory Services, X-rays and Medical Testing received in a Physician's office	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Occupational Therapy Services	$40 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Physical Therapy Services	$40 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Respiratory/Pulmonary Therapy Services	$40 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
Outpatient Speech Therapy Services	$40 Copayment, then 0% of Lesser Amount (2)	40% of Lesser Amount or Covered Charges after Deductible
Therapeutic Injections (including administration) received in a Physician's office	0% of Lesser Amount, not subject to Deductible	40% of Lesser Amount or Covered Charges after Deductible
All Other Covered Services	20% of Lesser Amount after Deductible	40% of Lesser Amount or Covered Charges after Deductible

Notes

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

1. Includes Office Visits to a Psychiatrist, Psychologist, Licensed Independent Social Worker, Licensed Professional Clinical Counselor and Licensed Marriage-Family Therapist.
2. If any of these Covered Services are received on the same day, only one $20 Copayment or $40 Copayment respectively will be charged per day.
3. If a diagnosis of a medical Condition is made during the screening (e.g., removal of a polyp), the procedure is no longer considered routine and may be considered a diagnostic procedure under Surgical Services.

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL HEALTH CARE BENEFIT BOOK

This Benefit Book describes the health care benefits available to you as a Covered Person in the Self Funded Health Benefit Plan (the Plan) offered to you by your Employer or your Union (the Group). 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 an Administrative Services Agreement between Medical Mutual Services (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.

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 provisions 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 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.

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

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

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

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

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

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

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

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

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

Contracting - the status of a Hospital or Other Facility 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.

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

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

- a group health plan, including church and governmental plans;
- health insurance coverage;
- Part A or Part B of Title XVIII of the Social Security Act (Medicare);

- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 (Medicaid);
- the health plan for active military personnel, including TRICARE;
- the Indian Health Service or other tribal organization program;
- a state health benefits risk pool;
- the Federal Employees Health Benefits Program;
- a public health plan as defined in federal regulations;
- a health benefit plan under section 5 (c) of the Peace Corps Act; or
- any other plan which provides comprehensive hospital, medical and surgical services.

Custodial Care - care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting 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 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.

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

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

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

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

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

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

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

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

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

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

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

Federally Eligible Individual -

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

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

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

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

Immediate Family - the 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-PPO Network Provider - a Physician or Other Professional Provider, Contracting Hospital or Contracting Other Facility Provider, Home Health Care Agency or Hospice Provider that is not designated by Medical Mutual as a PPO Network Provider.

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

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

- **Alcoholism Treatment Facility -** a facility which 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 which 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 which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- **Drug Abuse Treatment Facility -** a facility which mainly provides detoxification and/or rehabilitation treatment for Drug Abuse.
- **Home Health Care Agency -** a facility which meets the specifications of Chapter 3701.88 of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio and which provides nursing and other services as specified in the Home Health Care Services section of this 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 which provides supportive care for terminally ill patients as specified in the Hospice Services section of this Benefit Book.
- **Psychiatric Facility -** a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.
- **Psychiatric Hospital -** a facility which 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 which primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a Physician.

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

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

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

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

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

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

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

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

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

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

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

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

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

Residential Treatment Facility -

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

Rider - a document that amends or supplements your coverage.

Routine Services - Services not considered Medically Necessary.

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

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

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

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

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

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

Surgery -

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

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

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

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

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

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

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, or if certain conditions will not be covered during the Preexisting Condition Exclusion Period, if applicable.

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's or spouse's:
  - natural children;
  - stepchildren;
  - 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.

To be considered Eligible Dependents, children's ages must fall within the age limit specified in the Schedule of Benefits. For grandfathered plans, in addition to the age requirement, the children must not be eligible for other employer-sponsored coverage.

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 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.

If an Eligible Dependent child is being covered as a Full-time Student, and a Medically Necessary Leave of Absence causes such child to stop being a Full-time Student under the terms of this Benefit Book, the Eligible Dependent will continue to be covered under this Benefit Book until the earlier of one year, or the date coverage would otherwise end under the terms of this Benefit Book.

Medically Necessary Leave of Absence means a leave of absence from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that:

1. commences while such child is suffering from a serious illness or injury;
2. is Medically Necessary; and
3. causes such child to lose student status for purposes of coverage under the terms of this Benefit Book.

We must receive written certification by the treating Physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is Medically Necessary.

This provision is applicable only to those plans that require student status to continue coverage for a dependent child beyond the dependent age limit, as shown on the Schedule of Benefits.

Qualified Medical Child Support Order

In general, a Qualified Medical Child Support Order (QMCSO) is a court order that requires a Card Holder 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 Card Holders 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 Card Holder and alternate recipient of its determination. A copy of the Group's QMCSO procedures is also available upon request from the Group, without charge.

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 Card Holder. In addition, should the Card Holder 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 Group. 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.

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

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 divorce or legal separation
    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. A situation in which an individual incurs a claim that would meet or exceed a medical plan lifetime limit on all benefits (additional requirements apply)

j. Termination of an employee's or dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)

k. 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 "j" (termination of Medicaid or CHIP coverage) and "k" (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 "j" and "k" 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 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 Group if your coverage ends for any reason. After coverage ends, use of the identification card is not permitted and may subject you to legal action.

HEALTH CARE BENEFITS

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

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

Allergy Tests and Treatments

Allergy tests and treatments that are performed and related to a specific diagnosis are Covered Services. Desensitization treatments are also covered.

Ambulance Services

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

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

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

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

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

Case Management

Case management is an economical, common-sense approach to managing health care benefits. Medical Mutual's case management staff evaluates opportunities to cover cost-effective alternatives to the patient's current health care needs. Case management has proven to be very effective with catastrophic cases, long-term care, and psychiatric and substance abuse treatment. In such instances, benefits not expressly covered in this 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 care administered to a Covered Person participating in any stage of an eligible cancer clinical trial, if that care would be covered under the Plan if the Covered Person was not participating in a clinical trial.

"Eligible cancer clinical trial" means a cancer clinical trial that meets all of the following criteria:

- A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes;
- The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes;
- The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology; and
- The trial does one of the following:
  - Tests how to administer a health care service, item, or drug for the treatment of cancer;
  - Tests responses to a health care service, item, or drug for the treatment of cancer;
  - Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
  - Studies new uses of a health care service, item, or drug for the treatment of cancer;
  - The trial is approved by one of the following entities:
    - The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
    - The United States Food and Drug Administration;
    - The United States Department of Defense; or
    - The United States Department of Veterans' Affairs.

"Routine patient care" means all health care services consistent with the coverage provided under the Plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.

"Subject of a cancer clinical trial" means the health care service, item, or drug that is being evaluated in the clinical trial and that is not routine patient care.

No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the cancer clinical trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial 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 cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; and
- A service, item, or drug that is eligible for reimbursement by a person other than Medical Mutual, including the sponsor of the cancer clinical trial.

Contraceptive Services

Your coverage includes benefits for the following contraceptive services:

- injectable contraceptives, including the associated administration charges, when received in other than a Pharmacy.

Dental Services for an Accidental Injury

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

Diagnostic Services

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

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

You must obtain precertification from Medical Mutual prior to having the following diagnostic services performed:

- magnetic resonance angiography (MRA);
- magnetic resonance imaging (MRI); and
- positron emission tomography (PET).

Drug Abuse and Alcoholism Services

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

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

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

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

Drugs and Biologicals

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

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

Emergency Care Services

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

Health Education Services

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

Home Health Care Services

The following are Covered Services when you receive them in your home, 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 terminally ill Covered Person. Hospice services must be provided through a freestanding Hospice Facility or a hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Covered Person in a private residence.

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

The following Covered Services are considered hospice services:

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

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

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

Inpatient Hospital Services

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

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

- a semiprivate room or ward;
- a private room, when Medically Necessary; if you request a private room, 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;
- 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. **Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered;**
- anesthesia, anesthesia supplies and services;
- oxygen and other gases;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services;
- therapy services; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

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

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

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

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

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

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

Maternity Services

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy, miscarriage 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.

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 nurse midwife in applicable cases, determines further Inpatient postpartum care is not necessary for the mother or newborn child, provided the following are met:

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

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

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

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

Medical Care

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

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

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

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

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

Staff consultations required by Hospital rules are not covered.

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

Newborn 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 to examine, diagnose and treat a Condition are Covered Services.

Medical Nutrition Therapy Services

Medical nutrition therapy is the assessment of nutrition status followed by nutritional therapy. Nutritional therapy may include diet modification, counseling and education, disease self-management skills training and administration of special therapy such as medical foods, intravenous or tube feedings.

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:

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

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

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

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

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

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

Covered DME includes:

- blood glucose monitors;
- crutches;

- home dialysis equipment;
- hospital beds;
- mastectomy bra;
- respirators;
- wheelchairs.

Non-covered equipment includes but is not limited to:

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

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

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

Non-covered devices include but are not limited to:

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

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

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

Covered prosthetic appliances include:

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

Non-covered appliances include but are not limited to:

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

Mental Health Care Services

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

- individual and group psychotherapy;
- electroshock therapy and related anesthesia only if given in a Hospital or Psychiatric Hospital;
- psychological testing;
- family counseling: counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this 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, developmental delay, mental deficiency or retardation, other than those necessary to evaluate or diagnose these Conditions, are not covered. Services for the treatment of attention deficit disorder are covered. **Residential care rendered by a Residential Treatment Facility is not covered.**

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

Organ and Tissue Transplant Services

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

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

if such services take place during a transplant benefit period. A transplant benefit period is a period of time which starts five days before the day you receive your first covered transplant and ends 12 months later. A new transplant benefit period starts only if the next covered transplant occurs more than 12 months after the last covered transplant was performed. No transplant waiting periods and/or organ transplant maximums will apply to kidney, pancreas/kidney, bone marrow, tissue or cornea transplants.

Additional organ/tissue 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/Tissue Transplant Pre-Certification - In order to receive full benefits for an organ/tissue transplant, the proposed course of treatment must be pre-certified and approved by Medical Mutual. In the event you do not obtain precertification, and your organ transplant is determined to not be Medically Necessary or is determined to be Experimental/Investigational, you 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/tissue. You may also be required to undergo an examination by a Physician chosen by Medical Mutual. You and your Physician will then be notified of Medical Mutual's decision.

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

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

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

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

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

Outpatient Institutional Services

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

Covered Institutional services include, but are not limited to:

- operating, delivery and treatment rooms and equipment;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. 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. **Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered;**
- anesthesia, anesthesia supplies and services; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

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

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

Outpatient Therapy Services

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

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

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

Chiropractic Visits - The treatment given by a chiropractor to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. These Covered Services include, but are not limited to, Office

Visits, physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices. **Braces and molds are not covered under this benefit**.

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

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

Occupational Therapy - Occupational therapy services are covered if it is expected that the therapy will:

- result in a significant improvement in the level of functioning; and
- that improvement will occur within 60 days of the first treatment.

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

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

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

All physical therapy services must be performed by an appropriately licensed Provider.

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

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

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

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

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

Physical Medicine and Rehabilitation Services

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

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 or as an Inpatient. 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.

Inpatient 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 non-medical 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.

Routine and Wellness Services

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

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

Immunizations - Regardless of Medical Necessity, immunizations are covered for Covered Persons of all ages.

Routine Gynecological Services - The following services are covered:

- mammogram services; and
- PAP tests.

Routine Physical Examinations - Routine physical examinations are covered.

Routine Testing - the following services are covered for all Covered Persons:

- Laboratory services;
- Medical testing;
- X-rays; and
- Routine Endoscopic Procedures (meaning colonoscopy, sigmoidoscopy, anoscopy and proctosigmoidoscopy) are Covered Services. However, if a diagnosis of a medical Condition is made during a routine screening, (e.g., removal of a polyp), the screening is no longer considered routine and may be payable as a Medically Necessary, diagnostic procedure under the Surgical Services benefits. A Deductible, Copayment and/or Coinsurance may apply.

Routine Vision Examinations - Routine vision examinations are covered.

Skilled Nursing Facility Services

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

No benefits are provided:

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

Surgical Services

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

- sterilization, regardless of Medical Necessity;
- therapeutic and elective abortions;
- 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 Traditional Amount for the secondary procedures will be half of the Traditional Amount for a single procedure.

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

Oral Surgery - Coverage is provided for oral Surgery services. Benefits consist of operative and cutting procedures; these must be performed for the treatment of diseases and injuries of the jaw. The extraction of impacted teeth will not be covered.

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

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

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

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

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

EXCLUSIONS

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

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

24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
25. For weight loss Surgery 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.
26. For water aerobics.
27. For residential care rendered by a Residential Treatment Facility.
28. For marital counseling.
29. For the medical treatment of sexual problems not caused by a biological Condition.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For Contraceptives, except as specified.
32. For contraceptive devices which include, but are not limited to, IUD's, diaphragms and cervical caps.
33. For reverse sterilization.
34. For artificial insemination or in vitro fertilization.
35. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.
36. For oral implants considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic except when due to trauma, accident or as deemed Medically Necessary by Medical Mutual.
37. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
38. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
39. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.
40. For personal hygiene and convenience items.
41. For eyeglasses or contact lenses, except those for aphakic patients, keratoconus and soft lenses or sclera shells for use as corneal bandages when needed as a result of Surgery.
42. 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).
43. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them, except as specified.
44. For massotherapy or massage therapy.
45. For hypnosis and acupuncture.
46. For After Hours Care.
47. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
48. For fraudulent or misrepresented claims.
49. For blood which is available without charge. For Outpatient blood storage services.
50. For Prescription Drugs, except as specified.
51. For over the counter drugs, vitamins or herbal remedies.
52. For specialized camps.
53. For Routine Services, except as specified.
54. For a particular health service in the event that a Non-PPO Network Provider waives Copayments, Non-PPO Network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period) no benefits are provided for the health service for which the Copayments, Non-PPO Network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period) are waived.
55. For Temporomandibular Joint Syndrome (TMJ) services.
56. For orthoptic and pleoptic training.
57. For treatment of benign gynecomastia.
58. For the treatment of a psychosexual dysfunction.
59. For blepharoplasty, brow lift and blepharoptosis.
60. For rhinoplasty.

61. For genetic screening services.
62. 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 under the Members' section.

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 Provider's notes or other medical records before Proof of Loss is considered sufficient to determine benefit coverage.

Medical Mutual is not legally obligated to reimburse 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. No proof can be submitted later than one year after services have been received.

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

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

Benefit Period Deductible

Each Benefit Period, you must pay the dollar amount that may be specified in the Schedule of Benefits as the Deductible before 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. Copayments will not apply to the Deductible. Deductibles and Copayments do not apply to the Coinsurance Limit.

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

Only the amount of the Deductible required per Covered Person will be required for Covered Services that result directly from an accident during the Benefit Period in which the accident occurred if two or more Covered Persons in a Card Holder's family are injured in the same accident and each of the following conditions are met:

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

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

Coinsurance

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

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

Copayments

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

Schedule of Benefits

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

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

Your Financial Responsibilities

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

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

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

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

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

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

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

Provider Status and Direction of Payment

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

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

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 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 which are not considered Covered Services, then Medical Mutual has the right to recover payment on behalf of the Group, and you must repay this amount when requested.

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

Pre-Authorization of Non-PPO Network Benefits

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

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

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

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

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

Explanation of Benefits

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

Time of Payment of Claims

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

Benefit Determination for Claims

Urgent Care Claims

An **Urgent Care Claim** is a claim for Medical Care or treatment where applying the timeframes for non-urgent care could (a) 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 (a) an individual acting on behalf of the Plan and applying the judgment of a prudent lay person who possesses an average knowledge of medicine or (b) any Physician with a knowledge of the claimant's medical condition who can determine that a claim involves urgent care.

If you file an Urgent Care Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination, 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 all of the information necessary to make a benefit determination, Medical Mutual will notify you within 24 hours of receipt of the Urgent Care Claim of the specific deficiencies. You will have 48 hours to provide the requested information. Once Medical Mutual receives the requested information, we will notify you of the benefit determination as soon as possible 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

A Concurrent Care Claim is any claim for ongoing treatment, including a plan's approval for a number of treatments. The decision is adverse if the Plan decides to reduce or terminate benefits for the ongoing treatment (unless it's due to a health plan amendment or plan termination).

A request for an extension to an ongoing course of treatment must be filed in accordance with Medical Mutual's claim procedures and must be made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Medical Mutual will notify you of any benefit determination concerning the request to extend the course of treatment within 24 hours after its receipt of the claim.

If Medical Mutual reduces or terminates a course of treatment before the end of the course previously approved, the reduction or termination is considered an adverse benefit determination. Medical Mutual will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

Pre-Service Claims

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

If you file a Pre-Service Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination within 15 days after receipt of the claim. Medical Mutual may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of Medical Mutual. Medical Mutual will notify you of such an extension and date by which it expects to render a decision.

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

Post-Service Claims

A Post-Service Claim is any claim that is not a Pre-Service Claim.

If you file a Post-Service Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination within 30 days after receipt of the claim. Medical Mutual may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of Medical Mutual. Medical Mutual will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, Medical Mutual will notify you, in writing, within the initial 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.

Benefit Determination Notices

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

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of Medical Mutual's appeal procedures, applicable timeframes, including the expedited appeal process, if applicable;
- your right to bring a civil action under federal law following the denial of a claim after review on appeal, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA);
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, then that information will be provided free of charge upon written request;
- if the claim was denied based on Medical Necessity or Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your circumstances will be provided free of charge upon request.

Filing a Complaint

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

Filing an Appeal

Expedited Review Process

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

1. seriously jeopardize your life or health or your ability to regain maximum function or with respect to a pregnant woman, place the health of her unborn child in serious jeopardy; or
2. in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The appeal does not need to be submitted in writing. You or your Physician should call the Care Management telephone number on your identification card as soon as possible.

Expedited reviews will be resolved within 72 hours after you have submitted the request, with a possibility of extending to five calendar days with good cause.

The expedited review process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

Filing an Appeal

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

To submit an appeal electronically, go to Medical Mutual's Web site, www.MedMutual.com, under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card. You may also write a letter with 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, dental X-rays or photographs you would like considered in the appeal. Send or fax the letter and records to:

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

The request for review must come directly from the patient unless he/she is a minor or is 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.

You may appeal if your claim is denied because Medical Mutual determined (1) the Services received or requested were not Covered Services or (2) the Services received or requested to be received were not Medically Necessary.

First Level Mandatory Appeal for Medical Necessity Denial

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

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

Under the appeal process, there will be a full and fair review of the claim. The internal appeal process is a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations of Medical Necessity that are based in whole or in part on a medical judgment, are made by health care professionals who have the appropriate training and experience in the field of medicine involved in

the medical judgment. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

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

The appeal procedures are as follows:

Urgent Care Appeal

- You, your authorized representative or your Provider may request an appeal for urgent care. Urgent care claim appeals are typically those claims for Medical Care or treatment where withholding immediate treatment could seriously jeopardize the life or health of a patient or a patient's unborn child, or could affect the ability of the patient to regain maximum functions. The appeal must be decided within 72 hours of the request.

Pre-Service Claim Appeal

- You, your authorized representative or your Provider may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the plan Benefit Book. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of denial.

Post Service Claim Appeal

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

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

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based.
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the determination, then that information will be provided free of charge upon written request;
- if the claim was denied based on a Medical Necessity or Experimental treatment or similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be provided free of charge upon request;
- upon specific written request from you, provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- your right to bring civil action under federal law following the denial of a claim upon review, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

If your claim is denied for Medical Necessity at the first level mandatory appeal, you will be eligible for the Second Level Voluntary Internal Review Process.

Second Level Voluntary Internal Appeal

Unless your Group requires you to use an alternative dispute resolution procedure, if your first level mandatory appeal is denied, you have the option of a voluntary second level appeal by Medical Mutual. All requests for appeal may be made by calling Customer Service or writing to the Member Appeals Department. You should submit additional written comments, documents, records, dental X-rays, photographs and other information that were not submitted for the first level of appeal.

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

The voluntary second level of appeal provides a full and fair review of the claim. There will be a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into

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

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.

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, 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 <u>not</u> the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.
   c. Active employee or retired or laid-off employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an

active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

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

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

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

Effect On The Benefits Of This Plan

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

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. 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.

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. 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.

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. 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.

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

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

Changes In Benefits or Provisions

The benefits provided by this coverage may be changed at any time. It is your Group's responsibility to notify you when these changes go into effect. If you are receiving Covered Services under this 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 Book, stops:

- On the date under the terms and conditions of the Plan, as described in this Benefit Book, that 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.
- On the date that 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 a covered retiree, you have the right to continuation coverage if your employer has filed for reorganization under Chapter 11 of the Bankruptcy Code.

If you are the covered spouse of a 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 Eligible Dependent of a Card Holder, (active employee or retiree, for number six (6) below) covered by the Plan, he or she has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

1. the death of the 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 health coverage will end as of the date of the qualifying event.

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

How Long COBRA Coverage Will Continue

COBRA requires that you be offered the opportunity to maintain continuation coverage for 18 months if you lost coverage under the 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 health coverage to any of its employees;
2. the premium for your continuation coverage is not paid in a timely fashion;
3. you first become, after the date of election, covered under another group health plan (unless that other Plan contains an exclusion or limitation with respect to any preexisting Condition affecting you or a covered dependent); or
4. you first become, after the date of election, entitled (that is covered) under Medicare.

Additional Information

An Eligible Dependent who is a qualified beneficiary is entitled to elect continuation of coverage even if the 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 health plan if one is provided by the Group. However, conversion coverage is not available if the Agreement terminates or the Group goes out of business. Call the Group during your last 180 days of COBRA for information on conversion).

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

Continuation of Coverage During Military Service

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

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

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.

Federally Eligible Individuals

In addition, you need to be advised of what qualifies you to meet the requirements of a Federally Eligible Individual. Special non-group plans are available to Federally Eligible Individuals. A Federally Eligible Individual is an individual who meets the following requirements:

- an individual must have an 18 month period of Creditable Coverage, with final coverage through a group health plan, including church and governmental plans; health insurance coverage; Part A or Part B of Title XVIII of the Social Security Act (Medicare); the health plan for active military personnel, including TRICARE; the Indian Health Service or other tribal organization program; a state health benefits risk pool; the Federal Employees Health Benefits Program; a public health plan as defined in federal regulations; a health benefit plan under section 5 (c) of the Peace Corps Act; or any other plan which provides comprehensive hospital, medical and surgical services. Coverage after which there was a break of more than 63 days does not count in the period of Creditable Coverage. Creditable Coverage will be counted based on the standard method, without regard to specific benefits.

- an individual must enroll within 63 days of the termination date of your coverage under the group policy coverage;
- an individual must not be eligible for coverage under a group health plan, Medicare or Medicaid;
- an individual must not have other health insurance coverage;
- an individual whose most recent prior coverage has not been terminated for nonpayment of premium or fraud; and
- if the individual elected COBRA coverage or Ohio extension of coverage, the individual must exhaust all such continuation coverage to become a Federally Eligible Individual. Termination for nonpayment of premium does not constitute exhausting such coverage.

RETAIL AND HOME DELIVERY PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Benefit Period	Calendar Year
Dependent Age Limit	Please refer to your medical Schedule of Benefits
Days Supply	30 days for retail Prescription Drugs or 90 days for Home Delivery Prescription Drugs
Benefits provided under this Prescription Drug coverage will accumulate towards the medical Overall Benefit Period Maximum.	

The following Prescription Drug Covered Services are subject to the Prescription Drug Copayments each time services are received:

- asthmatic supplies limited to inhalation spacers
- diabetic supplies including over-the-counter supplies[1], insulin, syringes/needles,

COPAYMENTS FOR RETAIL PRESCRIPTION DRUG COVERED SERVICES		
TYPE OF SERVICE	**For Prescription Drug Covered Services received from a Participating Drug Provider** [2]	**For Prescription Drug Covered Services received from a Non-Participating Drug Provider** [2]
	YOU PAY THE FOLLOWING	
Generic Prescription Drugs	$10 Copayment	$10 Copayment
Brand Name Formulary Prescription Drugs	$30 Copayment	$30 Copayment
Brand Name Non-Formulary Prescription Drugs	$60 Copayment	$60 Copayment

COPAYMENTS FOR HOME DELIVERY PRESCRIPTION DRUG COVERED SERVICES		
TYPE OF SERVICE	**For Prescription Drug Covered Services received from a Contracting Home Delivery Pharmacy** [2]	**For Prescription Drug Services received from a Non-Contracting Home Delivery Pharmacy** [2]
	YOU PAY THE FOLLOWING	
Generic Prescription Drugs	$20 Copayment	Not Covered [3]
Brand Name Formulary Prescription Drugs	$60 Copayment	Not Covered [3]
Brand Name Non-Formulary Prescription Drugs	$120 Copayment	Not Covered [3]

[1] Over-the-counter supplies require a Prescription Order and do not include glucomonitors, glucometers and insulin pumps.
[2] Please refer to the Prescription Drug Benefits section for additional information.
[3] Benefits for Prescription Drugs are available when obtained from a retail Pharmacy.

PRESCRIPTION DRUG RIDER

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

PRESCRIPTION DRUG BENEFITS

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

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

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

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

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

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

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

Coverage during active military duty

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

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

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

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

- Medical Mutual, on behalf of the Plan, will provide 75% of the Prescription Drug Lesser Amount, minus the Prescription Drug Copayment or Prescription Drug Coinsurance, or both, as indicated in the Prescription Drug Schedule of Benefits. You must pay the Pharmacy the full amount of the bill for the Prescription Drug at the time of purchase. You must then file a claim form with Medical Mutual and payment will be made directly to you for 75% of the

Prescription Drug Lesser Amount, minus the Prescription Drug Copayment or Prescription Drug Coinsurance. You may be responsible for any amount in excess of the Prescription Drug Covered Charges.

HOME DELIVERY PRESCRIPTION DRUG BENEFITS

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

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

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

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

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

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

EXCLUSIONS

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

1. For contraceptive implants.
2. For contraceptive devices which include, but are not limited to, IUD's, diaphragms and cervical caps.
3. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.
4. For biologicals.
5. For immunization agents and vaccines.
6. For weight loss drugs.
7. For drugs dispensed for cosmetic purposes; used solely for beautifying or altering one's appearance in the absence of any underlying Condition.
8. For therapeutic devices.
9. For artificial appliances.
10. For disposable insulin needles and syringes which are not prescribed.
11. For hypodermic needles, syringes or comparable devices or appliances, except as specified.
12. For fluoride products.
13. For vitamins, except for prenatal vitamins.
14. For smoking cessation medications and products, except for Chantix.
15. For over the counter drugs, vitamins or herbal remedies.
16. For drugs you can buy without a Prescription Order.
17. For more than the number of Prescription Drug refills specified by the Physician.

18. For any refill of a Prescription Drug dispensed after one year from the date of the original Prescription Order.
19. For charges for more than the days supply of a Prescription Drug, as specified in the Prescription Drug Schedule of Benefits.
20. Incurred or received after you stop being a Covered Person.
21. For a Prescription Drug which is entirely consumed or administered at the time and place where the Prescription Order is issued.
22. For fees for administering or injecting Prescription Drugs.
23. For non-covered services or services specifically excluded in the text of this Rider.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Prescription Drug Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings (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 Prescription Drug Negotiated Amount will be based upon the agreement or arrangement Medical

Mutual has with the vendor and not upon the vendor's actual negotiated price with the Provider, subject to the further conditions and limitations set forth herein.

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