

JOHN CARROLL UNIVERSITY

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PPO Network Major Medical Health Care Benefit Book

NOTICE:

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

MEDICAL MUTUAL SERVICES, LLC

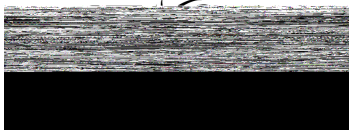
Our Member Frequently Asked Questions (FAQ) document is available to help you learn more about your rights and responsibilities; information about benefits, restrictions and access to medical care; policies about the collection, use and disclosure of your personal health information; finding forms to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

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This Amendment modifies the coverage described in your Benefit Book and is effective on January 1, 2022, unless stated otherwise. It is subject to all the terms and conditions of the Plan, except as stated. This Amendment terminates concurrently with the Plan to which it is attached. Please place this Amendment with your Benefit Book for future reference.

1. The following is added to the Schedule of Benefits:

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

2. The Schedule of Benefits is amended as follows:

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

Medicare reimbursement for that service. The Non-Contracting Amount will likely be less than the Provider's Billed Charges. Medical Mutual also reserves the right to pay a Non-Contracting Amount for Prescription Drugs received from a non-Network Pharmacy that is based on the lesser of the Billed Charges or an amount similar to or less than what Medical Mutual would pay a Network Pharmacy.

c. The following definition is added:

Independent Freestanding Emergency Department - a health care facility that:

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

4. The Health Care Benefit entitled, "Emergency Services" is deleted and replaced with the following:

Emergency Services

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

In the event of an emergency:

- call 911 or go to the nearest Hospital or Independent Freestanding Emergency Department; and
- notify Medical Mutual, by calling Customer Care at the phone number shown on your identification card, within 24 hours

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

6. **COVID-19 Coverage:** The following coverage is in effect during the national public health emergency declared by the Department of Human Health Services ("HHS") on January 31, 2020 (effective January 27, 2020), or as required by applicable state or federal law, if any provisions of this section are extended beyond the emergency period.
- a. Coverage is provided for certain diagnostic and preventive services related to COVID-19 without cost-sharing requirements (including Deductibles, Copayments and Coinsurance), prior authorization or other medical management requirements.
 - b. Actively-at-work or similar eligibility requirements may be relaxed for otherwise eligible Employees who are impacted by COVID-19 for certain situations, such as layoffs, furloughs, reduced hours or reduced pay.
 - c. Limited extensions are provided for certain notification requirements relative to special enrollment, COBRA elections and filing of claims and appeals.
 - d. To the extent state or federal law requires different benefits and/or coverage than described above, the Plan will be deemed to include those benefits and/or coverage.

IN WITNESS
WHEREOF:

Medical Mutual Services, LLC



Steven C. Glass
President & CEO

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

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

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

You may be charged more than one Copayment per visit if multiple types of examinations are performed.

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

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

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

COINSURANCE AND COPAYMENTS FOR COVERED SERVICES

TYPE OF SERVICE (Institutional and Professional)	For Covered Services received from a PPO Network Provider, you pay the following portion, based on the Allowed Amount	For Covered Services received from a Non-PPO Network or a Non-Contracting Provider, you pay the following portion, based on the applicable Allowed Amount or Non-Contracting Amount (3)
<p align="center">IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES <u>ARE</u> SUBJECT TO THE DEDUCTIBLE, UNLESS "NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.</p>		
Medically Necessary Office Visits in a Specialist's Office	\$35 Copayment, not subject to the Deductible	40%

3. The Coinsurance percentage will be the same for Non-Contracting Providers as Non-PPO Network Providers, but for Non-Contracting Providers, you may still be subject to balance billing and/or Excess Charges. Payments to Contracting Non-PPO Network Providers are based on the Allowed Amount. Payments to Non-Contracting Providers are based on the Non-Contracting Amount.
4. Contact Customer Care for more details.
5. Includes Office Visits to a Psychiatrist or Psychologist, Licensed Independent Social Worker

PPO NETWORK MAJOR MEDICAL HEALTH CARE BENEFIT BOOK

This Benefit Book describes the health care benefits available to you as a Covered Person in the Self-Funded Health Benefit Plan (the Plan) offered to you by your 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 a1 645.y

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.



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 descr

- if reliable evidence shows that the consensus of opinion among experts is that the drug, device, medical treatment or procedure is not the standard of care and that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis.

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

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

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

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

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

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

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

- appropriate with regard to the standards of good medical practice and not Experimental or Investigational;
- not primar

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

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

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

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

- advanced nurse practitioner (A.N.P.);
- ambulance services;
- certified dietician;
- certified nurse-midwife;
- certified nurse practitioner;
- clinical nurse specialist;
- dentist;
- doctor of chiropractic medicine;
- durable medical equipment or prosthetic appliance vendor;
- laboratory (must be Medicare Approved);
- licensed independent social workers (L.I.S.W.);
- licensed practical nurse (L.P.N.);
- licensed Professional clinical counselor;
- licensed Professional counselor;
- licensed vocational nurse (L.V.N.);

- mechanother

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

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

Rider - a document that amends or supplements your coverage

ELIGIBILITY

Enrolling for Coverage

Prior to receiving this Benefit Book, you enrolled, and were accepted or approved by your Group for individual co

the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

Effective Date

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

Changes in Coverage

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

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

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

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

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

Special Enrollment

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

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

3. If you or your Eligible Dependent has COBRA coverage, the coverage must be exhausted in order to trigger a special enrollment right. Generally, this means the entire 18, 29 or 36-month COBRA period must be completed in order to trigger a special enrollment for loss of other coverage.
4. Enrollment must be supported by written documentation of the termination of the other coverage with the effective date of said termination stated therein.

HEALTH CARE BENEFITS

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

Please refer to the "Prior Approval of Benefits Received from Non-PPO Network or Non-Contracting Providers" in the "How Claims Are Paid" section of the General Provisions for information regarding services received from Providers who are not in the PPO Network.

Women's Health and Cancer Rights Act Notice

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

Alcoholism and Drug Abuse Services

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

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

Inpatient admissions to a Hospital Provider or Residential Treatment Facility must be preauthorized. The telephone number for Preauthorization is listed on the back of your identification card. Contracting Providers and PPO Network Providers will assure that Preauthorization is done; since the Provider is responsible for obtaining Preauthorization, there is no penalty to you if this is not done. If a Non-Contracting Provider is utilized, **you** are responsible for obtaining Preauthorization. If you do not obtain Preauthorization, and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges.

Allergy Tests and Treatments

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

Ambulance Services

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

Covered transportation:

- from the scene of an accident or Emergency Medical Condition to the closest Hospital to provide Emergency Services;

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

It's important to note:

- Ambulance ser

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

- A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Dental Services for an Accidental Injury

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

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

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

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

Diagnostic Services

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

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

Drugs and Biologicals

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

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

Specialty Prescription Drugs require prior approval from Medical Mutual.

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

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

Step Therapy: a program to determine whether you qualify for coverage based upon certain information, such as medical history, drug history, age and gender. This program requires that you try another drug before the target drug will be covered under this Plan, unless special circumstances exist. If your Physician believes that special circumstances exist, he or she may request a coverage review.

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

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

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

Emergency Services

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

In the event of an emergency:

- call 911 or go to the nearest Hospital; and
- notify Medical Mutual, by calling Customer Care at the phone number shown on your identification card, within 24 hours, or as soon as medically possible, if the nearest Hospital is not in the PPO Network.

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

Home Health Care Services

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

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

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

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

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

Hospice Services

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

The following Covered Services are considered hospice services:

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

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

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

Inpatient Health Education Services

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

Inpatient Hospital Services

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

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

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

- any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

Covered Services will be provided whether receive

If your Group changes your health care benefits, causing an increase or decrease in your Inpatient Medical Care Visits allow

If the supplies, equipment and appliances include comfort, luxury or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your Condition, reimbursement will be based on the maximum allowable charge for a standard item that is a Cov

Covered Services for orthotic devices are:

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

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

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

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

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

Covered prosthetic appliances include:

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

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

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

Mental Health Care Services

Covered Services for the treatment of Mental Illness include:

- Inpatient treatment, including treatment in a Residential Treatment Facility;
- Outpatient treatment, including partial Hospitalization and intensive Outpatient services;
- individual and group psychotherapy;
- electroshock therapy and related anesthesia only if given in a Hospital or Psychiatric Hospital;
- psychological testing;
- counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Benefit Book. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient;
- 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 intellectual disability, other than those necessary to evaluate or diagnose these Conditions, are not covered. Services for the treatment of attention deficit disorder are covered.

Inpatient admissions to a Hospital Provider or Residential Treatment Facility Provider must be preauthorized. The telephone number for Preauthorization is listed on the back of your identification card. Contracting Providers and PPO Network Providers will assure that Preauthorization is done; since the Provider is responsible for obtaining Preauthorization, there is no penalty to you if this is not done. If a Non-Contracting Provider is utilized, **you** are responsible for obtaining Preauthorization. If you do not obtain Preauthorization, and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges.

Organ Transplant Services

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

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

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

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

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

After your Physician has examined you, he must provide Medical Mutual with:

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

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

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

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

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

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

- that are related to other than human organ.

Other Outpatient Services

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

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

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

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

Outpatient Institutional Services

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

Covered Institutional services include, but are not limited to:

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

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

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

Outpatient Rehabilitative Services

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

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

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

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

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

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

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

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

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

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

Preventive and Wellness Services

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

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

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

preventive services, please visit www.healthcare.gov/coverage/preventive-care-benefits. Newly added preventive services added by the advisory entities referenced by the Affordable Care Act will start to be covered on the first plan year beginning on or after the date that is one year after the new recommendations or guideline, went into effect. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of eligible services.

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

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

Testing - the following tests are covered:

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Surgical Services

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

- removal of bony impacted teeth;
- maxillary or mandibular frenectomy;
- diagnostic endoscopic procedures, such as colonoscopy and sigmoidoscopy;
- reconstructive Surgery following a mastectomy, including coverage for reconstructive Surgery performed on a non-diseased breast to establish symmetry as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas;
- Surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes as determined by Medical Mutual, subject to any appeal process. **Surgery to correct a deformity or birth defect for psychological reasons, where there is no functional impairment, is not covered.**

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

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

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

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

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

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

Second Surgical Opinion - A second surgeon's opinion and related diagnostic services to help determine the need for elective covered Surgery recommended b

Urgent Care Services

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

Examples of Urgent Care are:

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

EXCLUSIONS

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

1. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
2. Not performed within the scope of the Provider's license.
3. Not Medically Necessary or do not meet Medical Mutual's policy, clinical coverage guidelines, or benefit policy guidelines.
4. Received from other than a Provider.
5. For Experimental or Investigational drugs, devices, medical treatments or procedures, unless otherwise specified.
6. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
7. For a Condition that occurs as a result of any act of war, declared or undeclared.
8. For a Condition resulting from direct participation in a riot, civil disobedience, nuclear explosion or nuclear accident.
9. For which you have no legal obligation to pay in the absence of this or like coverage.
10. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
11. Received from a member of your Immediate Family.
12. Incurred after you stop being a Covered Person unless otherwise specified in the Benefits After Termination of Coverage section.
13. For the following:
 - physical examinations or services required by an insurance company to obtain insurance;
 - physical examinations or services required by a governmental agency such as the FAA and DOT;
 - physical examinations or services required by an employer in order to begin or to continue working.
14. For radiologic imaging with no preserved film image or digital record.
15. For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability or similar laws, even when the Covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.
16. For which benefits would have been payable under Part B of Medicare if a Covered Person had enrolled in Part B coverage. For the purposes of the calculation of benefits, if the Covered Person is eligible for, but has not enrolled in, Medicare Part B, Medical Mutual will calculate benefits as if he or she had enrolled. This provision only applies where Medicare is the primary payer under the law.
17. Received in a military facility for a military service related Condition.
18. For court-ordered testing or care unless Medically Necessary.
19. For Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss or weight loss Surgery), unless otherwise specified.
20. For weight loss Surgery and any repairs, revisions or modifications of such Surgery, including weight loss device removal, unless determined by Medical Mutual to be a Covered Service in accordance with Medical Mutual's corporate medical policy.
21. For Surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment.
22. For the removal of tattoos.
23. For dietary and/or nutritional counseling or training, unless otherwise specified or required by PPACA.
24. For Outpatient educational, vocational or training purposes, except as may be required by PPACA.
25. For treatment of learning disorders and intellectual disabilities, other than treatment necessary to evaluate or diagnose these Conditions.
26. For endoscopic screening procedures, other than colonoscopies and sigmoidoscopies required by PPACA.

27. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss or obesity.
28. For nutritional supplements taken orally.
29. For marital counseling.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For Contraceptives and over-the-counter birth control devices.
32. For Contraceptive devices, which include, but are not limited to, IUD's, diaphragms and cervical caps.
33. For sterilizations.
34. For reverse sterilization.
35. For devices, equipment and supplies used for the treatment of sexual dysfunction that is psychological or cosmetic in nature.
36. For therapeutic and elective abortions.
37. For treatment of infertility, including, but not limited to, artificial insemination, in vitro fertilization, Gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT).
38. For treatment associated with teeth, dental X-rays, dentistry or any other dental processes, including treatment with intraoral prosthetic devices or any other method to alter vertical dimension of occlusion, or orthognathic (jaw) Surgery. This exclusion does not apply to treatment of temporomandibular joint (TMJ) disorders.
39. For dental implants, considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic, except as described in the "Dental Services for an Accidental Injury" benefit.
40. For personal hygiene and convenience items.
41. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except as described in the section entitled "Prosthetic Appliances" under the "Medical Supplies and Durable Medical Equipment" benefit.
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.
44. For lost, stolen, or damaged medical supplies or durable medical equipment.
45. For massotherapy or massage therapy, except as directly performed by a licensed physical therapist, occupational therapist or chiropractor.
46. For hypnosis and acupuncture.
47. For biofeedback, unless determined by Medical Mutual to be a Covered Service in accordance with Medical Mutual's corporate medical policy.
48. For blood which is available without charge. For Outpatient blood storage services.
49. For Prescription Drugs, except as specified.
50. For preventive services, unless otherwise specified and in accordance with state and federal law.
51. For specialized camps.
52. For water aerobics.
53. For After Hours Care.
54. For missed appointments, completion of claim forms or copies of medical records.
55. For an interpretation charge by a pathologist when the interpretation or result is already automatically provided by a machine-read or automated laboratory test.
56. For stand-by charges of a Physician.
57. For any Charges not documented in Provider records.
58. For fraudulent or misrepresented claims.
59. For charges for doing research with Providers not directly responsible for your care.
60. For services as the result of an injury or illness caused by or contributed to by engaging in an assault or felony.
61. For a particular health service in the event that a Provider waives Copayments, Coinsurance (and/or the Deductible per Benefit Period); in such event, no benefits are provided for the health service for which the Copayments, Coinsurance (and/or the Deductible per Benefit Period) are waived.
62. For services billed by a Non-Contracting Provider that would not be covered if billed by a Contracting Provider, due to medical policy or other care map 0 1 289.32 74.2441(acting Pro)Gt0 1 70 0 1 373.005

harmless. If a Non-Contracting Provider bills the Covered Person for such services, the Covered Person is responsible for the cost of those services and must pay that Provider.

63. For non-Covered Services or services specifically excluded in the text of this Benefit Book.

Non-Contracting Providers

If you choose to obtain services from a Non-Contracting Provider, your out-of-pocket expenses will likely be significantly higher than what you would pay by choosing a PPO Network Provider. Copayments, Deductibles and Coinsurance are usually higher when utilizing a Non-Contracting Provider, as shown on the Schedules of Benefits. Also, Medical Mutual calculates its payments to Non-Contracting Providers based upon the Non-Contracting Amount. This means that in addition to your increased out-of-pocket expenses described above, you may also be responsible for Excess Charges, up to the amount of the Provider's Billed Charges. This is sometimes referred to as "balance billing." Excess Charges billed by Non-Contracting Providers DO NOT apply to the Out-of-Pocket Maximum.

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

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

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

Any charges exceeding the Allowed Amount, Non-Contracting Amount or the amount payable for Emergency Ser

- the combined Allowed Amount for Covered Services for all Covered Persons involved in the accident is at least equal to one Covered Person's Deductible.

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 applicab

If a benefit payment is made by Medical Mutual, to you or to your Provider on your behalf, that exceeds the benefit amount you are entitled to receive, Medical Mutual has the right to require the return of the overpayment from you or your Provider within two years of the payment. If Medical Mutual seeks payment from your Provider, Medical Mutual will first send an invoice to the Provider that explains why it is seeking a refund. The Provider can then send the refund or appeal the determination.

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

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

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

Explanation of Benefits

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

Time of Payment of Claims

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

Foreign Travel

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

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

Cir

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, and your complaint is regarding an Adverse Benefit Determination, you may continue to pursue the matter through the appeal process.

Benefit Determination for Claims (Internal Claims Procedure)

Claims Involving Urgent Care

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

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

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

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

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

Concurrent Care Claims

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

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

Pre-Service Claims

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

appropriate to the medical circumstances, but nos Tm(, b)Tj1 0T b

Filing an Appeal

If you are not satisfied with any of the following:

- a benefit determination;
- a Medical Necessity determination;
- a determination of your eligibility to participate in the plan or health insurance coverage; or
- a decision to rescind your coverage (a rescission does not include a retroactive cancellation for failure to timely pay required premiums)

then you may file an appeal.

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 for more information about how to file an appeal. You may also wr

If, during the appeal, Medical Mutual considers, relies upon or generates any new or additional evidence, you will be provided free of charge with copies of that evidence before a notice of final Adverse Benefit Determination is issued. You will have an oppor

- if the Adverse Benefit Determination was based on a Medical Necessity, Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the ter

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review.
The IR

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 n r

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

that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

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

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
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- 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 an

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.

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 cov

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

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

Rescission of Coverage

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

You will be pro

2024

