CLEVELAND HEIGHTS/UNIVERSITY HEIGHTS BOARD OF EDUCATION

Group Number
382133-041

Prescription Drug Benefit Book

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

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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

RETAIL AND HOME DELIVERY PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Benefit Period	Calendar Year
Dependent Age Limit	The end of the month of the 26th birthday.
Days Supply	34 days for retail Prescription Drugs or 100-unit dose, whichever is greater 90 days for Home Delivery Prescription Drugs

The following Covered Prescription Drug Services are subject to Prescription Drug Copayments and Home Delivery Copayments each time services are received:

insulin, syringes/needles, and diabetic blood/urine test strips.[1]
antiobesity drugs
fluoride toothpaste products (Federal Legend)
Isotretinoin (Accutane) through the age of 25
Retin-A/Avita and Tazorac

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	$6 Copayment	$6 Copayment
Brand Name Prescription Drugs for which no Generic Prescription Drug is available or manufactured	$12 Copayment	$12 Copayment
Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	$18 Copayment	$18 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-Contacting Home Delivery Pharmacy**[2]
	YOU PAY THE FOLLOWING	
Generic Prescription Drugs	$6 Copayment	Not Covered [3]
Brand Name Prescription Drugs for which no Generic Prescription Drug is available or manufactured	$12 Copayment	Not Covered [3]
Brand Name Prescription Drugs for which a Generic Prescription Drug is available or manufactured	$18 Copayment	Not Covered [3]

[1] Over-the-counter supplies require a Prescription Order.
[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 BENEFIT BOOK

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

The actual Group Contract is between Medical Mutual (Medical Mutual) and the Plan Sponsor.

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

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

The Plan Administrator shall have the 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 discretion of Medical Mutual and the Plan Sponsor and such decisions shall be final and conclusive.

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

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

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

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

HOW TO USE YOUR BENEFIT BOOK

This Benefit Book describes your Prescription Drug benefits. Please read it carefully.

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

The **Eligibility** section outlines how and when you and your dependents become eligible for coverage under the Plan and when this coverage starts. It also specifies the age limit for all eligible children.

The **Prescription Drug 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 Prescription Drug Benefits section.

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

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

ELIGIBILITY

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 Employee

An Eligible Employee is:

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

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.

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.

Child Support Order

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

Effective Date

Coverage starts at 12:01 a.m. on the Effective Date. 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 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

If you were eligible to enroll under the Plan and declined coverage because of other coverage, and you or your dependent lose the other coverage, you and your Eligible Dependent(s) will be permitted to enroll during a special enrollment period if loss of the other coverage was due to:

- termination of employment;
- a reduction in hours of employment;
- termination of the other coverage;
- termination of employer contributions toward coverage;
- the exhaustion of COBRA continuation coverage;
- the exhaustion of applicable lifetime benefits under the coverage;
- an individual ceases to be a dependent under the plan;
- the plan terminates a benefit package option;
- if your coverage is provided through a Health Maintenance Organization (HMO) or other arrangement, and you no longer live or work in the HMO's or other arrangement's service area (and there is no other coverage available under the plan);
- the plan no longer offers coverage to a class of similarly situated individuals that includes you (e.g., the plan terminates coverage for all part-time employees);
- layoff; or
- the death of or divorce from your spouse.

Enrollment must be supported by written documentation of the termination of the other coverage (including the effective date of the termination). Notice of intent to enroll must be provided to Medical Mutual within 31 days of the event with coverage to be effective on the date the other coverage terminated.

In addition, 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 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.

PRESCRIPTION DRUG BENEFITS

The Plan will provide benefits for the Prescription Drug Lesser Amount, minus the Prescription Drug Copayment for Medically Necessary Prescription Drugs and refills as described below and in the Prescription Drug Schedule of Benefits. 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.

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 or Prescription Drug Coinsurance. In this case, your liability is limited only to the Prescription Drug Lesser Amount.

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

Your coverage also provides benefits for drugs whose FDA approval indication is primarily for weight loss.

Unless your Physician specifies that you are to receive a Brand Name Prescription Drug, you may decide whether your Prescription Order is filled with a Generic Prescription Drug or a Brand Name Prescription Drug.

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 devices which include, but are not limited to, IUD's, diaphragms and cervical caps.
2. For contraceptive injections and implants.
3. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.
4. For personal hygiene and convenience items.
5. For the medical treatment of sexual problems not caused by a biological Condition.
6. For drugs dispensed for cosmetic purposes; used solely for beautifying or altering one's appearance in the absence of any underlying Condition.
7. For Isotretinoin (Accutane) for patients age 26 and older.
8. For dietary and flouride supplements except as specified.
9. For immunization agents.
10. For growth hormones.
11. For therapeutic devices.
12. For artificial appliances.
13. For disposable insulin needles and syringes which are not prescribed.
14. For hypodermic needles, syringes or comparable devices or appliances, except as specified.
15. For over-the-counter vitamins, herbal remedies and drugs, other than certain proton pump inhibitors that may be covered.
16. Not performed within the scope of the Provider's license.
17. Not prescribed by or performed by or under the direction of a Physician.
18. Received from a member of your Immediate Family.
19. For drugs you can buy without a Prescription Order.
20. For more than the number of Prescription Drug refills specified by the Physician.
21. For any refill of a Prescription Drug dispensed after one year from the date of the original Prescription Order.
22. For charges for more than the days supply of a Prescription Drug, as specified in the Prescription Drug Schedule of Benefits.
23. Incurred or received after you stop being a Covered Person.
24. For a Prescription Drug which is entirely consumed or administered at the time and place where the Prescription Order is issued.
25. For fees for administering or injecting Prescription Drugs.
26. 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.
27. 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.
28. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by the Plan.
29. For a Condition that occurs as a result of any act of war, declared or undeclared.
30. Received in a military facility for a military service related Condition.
31. For fraudulent or misrepresented claims.
32. For which you have no legal obligation to pay in the absence of this or like coverage.
33. For which payment was made or would have been made under Medicare Parts A or 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.

34. For Experimental or Investigational Drugs.
35. For treatment of conditions related to an autistic disease of childhood, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation.
36. 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

When you obtain Prescription Drugs and refills outside the state of Ohio or from a Non-Participating Drug Provider, you must file a claim form to be reimbursed for the Pharmacy charge. 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 Member's 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 Prescription Drug services which has been submitted to Medical Mutual for processing with sufficient documentation to determine whether Covered Services have been provided to you. Medical Mutual must receive a completed claim with the correct information.

Medical Mutual is not legally obligated to reimburse 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.

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

If you are not satisfied with a benefit determination decision, you may file an appeal. Appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of benefits. The appeal process is not available for services that are excluded in your Medical Mutual Benefit Book or when you have reached your maximum covered benefits.

All appeals for Prescription Drug benefits will be handled by licensed pharmacists or Physicians from Medical Mutual's Pharmacy Benefits Manager. Appeals for Medical Necessity of Prescription Drugs will follow a two-level appeal process. Each level will be decided within 15 days of Medical Mutual's Pharmacy Benefits Manager's receipt of your request for appeal. Urgent care appeals will be decided within 72 hours of receipt of your request.

You may submit your appeal for Medical Necessity of a Prescription Drug along with pertinent medical information to:

Pharmacy Benefits Manager
Attn: Coverage Reviews
8111 Royal Ridge Parkway
Irving, TX 75063
Telephone: 1-800-864-1135
FAX: 1-888-235-8551

Unless your Group requires you to use an alternative dispute resolution procedure, all other appeals, such as those related to eligibility or benefit coverage, should be submitted to:

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

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

Claim Review

Consent to Release Medical Information - Denial of Coverage

You consent to the release of medical information to Medical Mutual when you sign an Enrollment Form.

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

Right to Review Claims

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

Legal Actions

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

Coordination of Benefits

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

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without

regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

Definitions

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

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

   When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.
4. **Allowable expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an **Allowable expense**.

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

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

Order Of Benefit Determination Rules

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

1. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.
2. a. Except as provided in Paragraph "b" below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.
   b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
3. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
4. Each **Plan** determines its order of benefits using the first of the following rules that apply:
   a. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.
   b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order of benefits is determined as follows:
      1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
         - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
         - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.
         - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
      2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
         b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
         c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
         d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            - The **Plan** covering the **Custodial parent**;
            - The **Plan** covering the spouse of the **Custodial parent**;

- The **Plan** covering the **non-custodial parent**; and then
- The **Plan** covering the spouse of the **non-custodial parent**.

3. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

Effect On The Benefits Of This Plan

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

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Coordination Disputes

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

Right of Subrogation and Reimbursement

Subrogation

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

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

Reimbursement

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

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

Your Duties

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

Discretionary Authority

The Plan and/or 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. The Plan and/or 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, Medical Mutual 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 Plan immediately of any change to the eligibility status of a Full-time Student and/or Eligible Dependent child.
- On the date the Card Holder becomes ineligible.
- At the end of the period for which the premium was made when a Covered Person does not pay the next required contribution.
- 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 Plan or Medical Mutual or commits fraud or forgery.

Federal Continuation Provisions - COBRA

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

When You Are Eligible for COBRA

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

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

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

In the case of an active employee, or Eligible Dependent of a Card Holder covered by the Plan, he or she has the right to continuation coverage if group 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 you go on active duty in the U.S. armed forces, you will cease to be covered under the regular group health plan as of the end of the month in which you enter active military service. However, you have the following rights to continue coverage:

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

c. You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

DEFINITIONS

Application - all questionnaires and forms required by Medical Mutual to determine your eligibility and insurability.

Benefit Book - this document.

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.

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

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

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

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

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.

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 Prescription Drug Schedule of Benefits or the Prescription Drug Benefits section of this Benefit Book for which Medical Mutual will provide benefits.

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

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

Experimental or Investigational Drug - a drug is Experimental or Investigational:

- if the drug 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 is furnished;
- if reliable evidence shows that the drug is the subject of on-going phase I, II or III clinical trials or is under study to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or
- if reliable evidence shows that the consensus of opinion among experts regarding the drug 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; or the written informed consent used by the treating facility or by another facility studying substantially the same drug. Determination will be made by Medical Mutual at its sole discretion and will be final and conclusive.

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.

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.

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

Incurred - rendered to you by a Provider.

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

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.

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

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

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

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

Prescription Drug (Federal Legend Drug) - a drug that is required under Federal and/or State laws to be dispensed or delivered as prescribed on a Prescription Drug Order.

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.

Provider - a licensed Pharmacy or Physician.

Rider - a document which amends or supplements your coverage.

Multi-Language Interpreter Services & Nondiscrimination Notice

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

Spanish

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

Chinese

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

German

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

Arabic

ملحوظة:إذاكنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم (711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

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

Nondiscrimination Notice

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

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

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

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900
Email: CivilRightsCoordinator@MedMutual.com

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

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