

SHAKER HEIGHTS CITY SCHOOLS

Group Number

880997 - 003,103,203,303,403,503,603,703

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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PRESCRIPTION DRUG SCHEDULE OF BENEFITS

This Plan uses a Prescription Drug Formulary. Prescription Drugs not listed on the Formulary are generally not covered. See the Prescription Drug Benefit description for more information.

Specialty Prescription Drugs are covered under this benefit when obtained through Medical Mutual's preferred specialty pharmacy and are limited to a maximum of a thirty (30) day supply. Specialty Prescription Drugs require prior approval from Medical Mutual.

Benefit Period	Calendar Year
Dependent Age Limit	The end of the month of the 26th birthday
Prescription Drug Out-of-Pocket Maximum	
If you have single coverage	\$7,400
If you have family coverage	\$14,800
Maximum Days' Supply	30 for retail Prescription Drugs 30 days for Specialty Prescription Drugs 90 days for Home Delivery Prescription Drugs

BENEFIT PERIOD MAXIMUMS PER COVERED PERSON

Erectile Dysfunction Drugs	10 pills per 30 day supply (Retail) / 30 pills per 90 day supply (Home Delivery)
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RETAIL PHARMACY BENEFIT - UP TO A 30 DAY SUPPLY

TYPE OF SERVICE	For Covered Services, you pay the following portion, based on the Prescription Drug Allowed Amount
Generic Prescription Drugs	\$7 Copayment
Preferred Brand Name Prescription Drugs	\$25 Copayment
Non-Preferred Brand Name Prescription Drugs	\$50 Copayment
Prescribed Generic Prescription Drug Contraceptives or Brand Name Prescription Drug Contraceptives when an equivalent Generic Prescription Drug Contraceptive is not available	\$0 Copayment
Preventive Prescription Drugs and Vaccines in accordance with state and federal law.	\$0 Copayment
Prescription Drugs received from non-Network Pharmacies	You pay the entire amount at the Pharmacy and file a claim form with Medical Mutual. Medical Mutual will reimburse you based on the Prescription Drug Allowed Amount, minus the Prescription Drug Copayment or Coinsurance, as indicated. You may be responsible for any amount in excess of the Prescription Drug Covered Charges. If the Prescription Drug is not available from a Network Pharmacy, you will not be subject to this reduced reimbursement.

CONTRACTING HOME DELIVERY PHARMACY BENEFIT - 90 DAYS SUPPLY	
TYPE OF SERVICE	For Covered Services received from a CONTRACTING Home Delivery Pharmacy, you pay the following portion, based on the Prescription Drug Allowed Amount
Generic Prescription Drugs	\$17.50 Copayment
Preferred Brand Name Prescription Drugs	\$62.50 Copayment
Non-Preferred Brand Name Prescription Drugs	\$125 Copayment
Prescribed Generic Prescription Drug Contraceptives or Brand Name Prescription Drug Contraceptives when an equivalent Generic Prescription Drug Contraceptive is not available	\$0 Copayment
Preventive Prescription Drugs and Vaccines in accordance with state and federal law.	\$0 Copayment

Coverage is provided for Contracting Home Delivery Pharmacies only. Services received from any Non-Contracting Home Delivery Pharmacy are excluded.

PRESCRIPTION DRUG BENEFIT BOOK

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

There is an Administrative Services Agreement between Medical Mutual Services (Medical Mutual) and the Group pursuant to which claims are processed on behalf of the Plan.

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 Group.

The Group and Medical Mutual 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.

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. Coverage will not begin until your enrollment has been approved and you have been given an effective date.

Under individual coverage, only the Card Holder is covered. Under family coverage, the Card Holder and the Eligible Dependents who have been enrolled are covered.

Eligible Employees

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. Any applicable waiting period must be satisfied, but will not exceed 90 days.

No person who is eligible to enroll will be denied enrollment based upon health status, health care needs, genetic information, previous medical information, disability or age.

Eligible Dependents

An Eligible Dependent is:

- the Card Holder's spouse, provided you are not legally separated;
- the Card Holder's or spouse's:
 - natural children;
 - stepchildren, provided the natural parent remains married to the Card Holder and resides in the household;
 - 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 intellectual disability which renders them unable to support themselves. This incapacity must have started before the age limit was reached and must be medically certified by a Physician. You must notify your Group of the Eligible Dependent's desire to continue coverage within 31 days of reaching the limiting age. After a two-year period following the date the Eligible Dependent meets the age limit, the Plan may annually require further proof that the dependence and incapacity continue.

Child Support Order

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

Effective Date

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

Changes in Coverage

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

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

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

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

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

Special Enrollment

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

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

3. If you or your Eligible Dependent has COBRA coverage, the coverage must be exhausted in order to trigger a special enrollment right. Generally, this means the entire 18, 29 or 36-month COBRA period must be completed in order to trigger a special enrollment for loss of other coverage.
4. Enrollment must be supported by written documentation of the termination of the other coverage with the effective date of said termination stated therein. With the exception of items "j" (termination of Medicaid or CHIP coverage) and "k" (eligibility for premium assistance) above, notice of intent to enroll must be provided to Medical Mutual by the Group no later than thirty-one (31) days following the triggering event with coverage to become effective on the date the other coverage terminated. For items "j" and "k" above, notice of intent to enroll must be provided to Medical Mutual by the Group within sixty (60) days following the triggering event, with coverage to become effective on the date of the qualifying event.

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

Your Identification Card

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

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

PRESCRIPTION DRUG BENEFITS

Unless otherwise indicated, the paragraphs within this benefit apply to Prescription Drugs received from both retail Pharmacies and through the Home Delivery Program.

The Plan will provide benefits for Medically Necessary Prescription Drug Covered Services that are dispensed for your Outpatient use. All Prescription Drugs and refills must be prescribed by a Physician or other Professional Provider who is licensed by his or her state to write prescriptions ("Prescriber").

FORMULARY-ONLY COVERAGE: YOUR PRESCRIPTION DRUG BENEFIT COVERS ONLY THOSE PRESCRIPTION DRUGS LISTED ON MEDICAL MUTUAL'S FORMULARY.

Medical Mutual will consider making an exception to cover a non-Formulary Prescription Drug when your Physician provides evidence that the Formulary Prescription Drug(s) has been ineffective in the treatment of your Condition or is reasonably expected to cause you a harmful or adverse reaction. If an exception is made, your Copayment, Deductible, and/or Coinsurance, if applicable, will be the same as that for a Formulary Prescription Drug. You have the right to request an appeal of our decision by following the appeals process described later in this Benefit Book.

Medical Mutual may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs. Covered Services will be limited based upon Medical Necessity, quantity and/or age limits established by Medical Mutual or utilization guidelines. Medical Mutual may require utilization programs, such as Quantity Limits on certain Prescription Drugs. These programs are described further below. The Medical Necessity decisions are made by going through a coverage review process. More information on this coverage review process can be found in the Prescription Drug benefit member material sent separately. You may also call Customer Service at the phone number shown on your identification card for details.

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.

Specialty Prescription Drugs are covered under this benefit when obtained through Medical Mutual's preferred specialty pharmacy and are limited to a maximum of a thirty (30) day supply. Specialty Prescription Drugs require prior approval from Medical Mutual.

Benefits will be provided based on the Prescription Drug Allowed Amount. The Covered Person's Deductible, Copayment or Coinsurance is based upon the amount charged by the Pharmacy and does not include any rebates received by Medical Mutual. The Covered Person is responsible for any Copayment, Coinsurance or Deductible amounts specified in the Schedule of Benefits. The requirement to pay the applicable cost sharing (Deductible, Copayments or Coinsurance) cannot be waived by a Provider, a Pharmacy or anyone else under any "fee forgiveness," "not out-of-pocket," "discount program," "coupon program" or similar arrangement. Additionally, applicable cost sharing amounts cannot be paid for using funds from a patient assistance program, regardless if the member is receiving such assistance due to financial need from a pharmaceutical manufacturer, government program, or a charitable organization. Pharmaceutical manufacturers may sponsor patient assistance programs (PAPs) that provide financial assistance or drug free products (through in-kind product donations) to low income individuals to augment any existing prescription drug coverage. If you receive any amount from a patient assistance program or if a Provider, a Pharmacy or anyone else waives the required cost sharing (Deductible, Copayments, Coinsurance) for a particular claim, the cost sharing amounts covered by the patient assistance program or waived shall not be considered as true out-of-pocket expenses for Covered Persons, and these amounts shall not apply to Deductibles and/or Out-of-pocket Maximums.

If the Prescription Drug or injectable insulin Allowed Amount is less than the Prescription Drug Copayment, your liability is limited to the Prescription Drug Allowed Amount only.

You are required to present your identification card to the Pharmacy each time you obtain Prescription Drugs. If you do not present your identification card, or you do not go to a Network Pharmacy, you may pay a higher price for your Prescription Drugs or be responsible for Excess Charges.

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.

Your coverage also provides benefits for:

- certain preventive drugs required by PPACA when a written prescription from your Prescriber is received. These PPACA-required drugs are covered at a zero Copayment, but specific ages and quantity limits apply.
- oral, injectable, and implantable contraceptives and transdermal patches.
- injectable medications, if self-administered.
- injectable insulin, needles and syringes.

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

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 may be established at approximately six months of the FDA approval. Some Prescription Drugs approved by the FDA may never qualify as Medically Necessary.

An off-label Prescription Drug will not be excluded for a particular indication on the grounds that the drug has not been approved by the FDA for the particular indication if the drug is recognized for safe and effective treatment of the indication for which the drug was prescribed in at least one (1) standard medical reference compendia adopted by the U.S. Department of Health and Human Services or in other qualified medical literature. "Medical literature" means:

- Two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed;
- No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed;
- Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services as acceptable peer-reviewed medical literature.

However, no benefits will be provided if:

- the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
- the drug has not been approved for any indication by the FDA;
- the drug is not included in the Formulary or list of covered drugs provided by Medical Mutual.

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 the Plan, explain the situation and provide your name, identification number, the medications that need to be filled and the number of months supply needed.

Home Delivery program

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.

To receive Home Delivery Prescription Drug benefits, mail your Prescription Drug Order and the amount you owe for Copayments, Deductibles and/or Coinsurance, to a Contracting Home Delivery Pharmacy, as specified in the Schedule of Benefits. No benefits are payable if your Prescription Drug Order is sent to a Non-Contracting Home Delivery Pharmacy.

The Contracting Home Delivery Pharmacy will fill your Prescription Drug 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 seven days. If the Contracting Home Delivery Pharmacy fails to send you the Home Delivery Prescription Drug within ten days after you mailed in your Prescription Drug Order, you may call the Contracting Home Delivery Pharmacy directly to determine the status of the Prescription Drug Order.

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. Drugs not covered on the Formulary, except as described in the Prescription Drug Benefits section.
2. Not performed within the scope of the Provider's license.
3. Not prescribed by or performed by or under the direction of a Physician.
4. Received from a member of your Immediate Family.
5. Incurred or received after you stop being a Covered Person.
6. 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.
7. 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.
8. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by the Plan.
9. For a Condition that occurs as a result of any act of war, declared or undeclared.
10. Received in a military facility for a military service related Condition.
11. For fraudulent or misrepresented claims.
12. For which you have no legal obligation to pay in the absence of this or like coverage.
13. 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.
14. For treatment of conditions related to an autistic disease of childhood, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation.
15. Drugs dispensed for cosmetic purposes; used solely for beautifying or altering one's appearance in the absence of any underlying Condition.
16. Therapeutic devices.
17. Artificial devices.
18. Drugs you can buy without a Prescription Order.
19. Lost, stolen or damaged Prescriptions.
20. Prescription Drugs that have been determined by Medical Mutual to be abused or otherwise misused.
21. More than the number of Prescription Drug refills specified by the Physician.
22. Any refill of a Prescription Drug dispensed after the length of time allowed by law.
23. Charges for more than the days supply of a Prescription Drug, as specified in the Prescription Drug Schedule of Benefits.
24. Experimental or Investigational Drugs (including ingredients in compounds).
25. Fraudulent or misrepresented claims.
26. Fees for administering or injecting Prescription Drugs, except for vaccines covered under PPACA.
27. Compound medications in which the active ingredients do not require a Prescription Order or are not determined to be Medically Necessary.
28. Diagnostic, imaging and test agents and devices except for those used for blood glucose testing, or diabetes.
29. Male contraceptives and over-the-counter birth control without a prescription.
30. The treatment of infertility, either through injectable or oral medication.
31. Prescription Drugs that have an over-the-counter equivalent available.
32. Enteral or parenteral therapy, medical food, nutritional or dietary supplements or supplies.

33. Infant formula.
34. Drug used to decrease or increase weight gain or appetite control, or to treat obesity.
35. Weight loss drugs.
36. Minerals and vitamins, unless required by PPACA.
37. Refilled prescriptions if less than 75% of the original prescriptions (or subsequent refill) has been used.
38. Prescription Drug claims submitted 366 days after being filled.
39. Disposable insulin needles and syringes which are not prescribed by a Physician.
40. Allergy biological sera.
41. Allergy sera, toxoids and vaccines.
42. For depigmentation agents.
43. Prescriptions for household pets.
44. Over-the-counter items and drugs, unless required by law.
45. Anabolic steroids.
46. Medical supplies, devices and equipment.
47. Drugs for the treatment of acne (e.g., Retin A tretinoin) for Covered Persons over age 30 years.
48. Any blood and blood plasma products.
49. Homeopathic drugs in any dosage form.
50. Prescription Drugs used to treat dental conditions, including, but not limited to, the treatment of gingivitis.
51. 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:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis MO 63166-6588
Fax: 1-877-852-4070

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 Application.

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 attempt to resolve the problem by contacting Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card.

Subrogation and Right of Recovery

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. Benefit payments made under the Plan are conditioned upon your obligation to reimburse the Plan in full from any recovery you receive for your injury, illness or condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or

proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the Plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Future Benefits

If you fail to cooperate with and reimburse the Plan, the health plan reserves the right to deny any future benefit payments on any other claim made by you until the Plan is reimbursed in full. However, the amount of any covered services excluded under this section will not exceed the amount of your recovery.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Discretionary Authority

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

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 stops:

- On the date a Covered Person stops being an Eligible Dependent or if coverage is extended by your Group for Full-time Student status, on the date the Full-time Student status ends. You are responsible for notifying The Group immediately of any change to the eligibility status of a Full-time Student.
- At the end of the month in which the Card Holder becomes ineligible, when a Covered Person stops being an eligible Card Holder.
- On the day a final decree of divorce, annulment or dissolution of the marriage is filed, a Card Holder's spouse will no longer be eligible for coverage under the Plan.
- Immediately upon notice if:
 - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
 - a Covered Person materially misrepresents a material fact provided to the Group or Medical Mutual or commits fraud or forgery.

Continuation of Coverage

If any Covered Person's Group coverage would otherwise end, you and your Eligible Dependents may be eligible for continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You may also be eligible to continue benefits under other state or federal laws as a result of employment termination. 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.

Your Group's benefits administrator can coordinate your continuation of coverage. To obtain specific details and to arrange for continuation of Group health care benefits, contact your Group's benefits administrator as soon as possible.

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 (or 36 months if any of the following occurs during this 24-month period: death of the reservist; divorce or separation of a reservist from the reservist's spouse; or a child ceasing to be an Eligible Dependent); 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

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

Benefit Book - this document.

Biosimilar Prescription Drug - a Prescription Drug that:

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

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

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.

Contracting Specialty Pharmacy - a Pharmacy which dispenses Specialty Prescription Drugs 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 under the Plan begins, as determined by your Group.

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

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, subject to any available appeal process.

Formulary - a list of Generic Prescription Drugs, Brand Name Prescription Drugs and over-the-counter drugs that are covered under this plan.

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.

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

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.

Network Pharmacy - a Pharmacy who has a network agreement to provide Prescription Drug services.

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

Out-of-Pocket Maximum - a specified dollar amount of Deductible, Coinsurance and Copayment expense, including any applicable Prescription Drug Deductibles, Coinsurance and Copayments, Incurred in a Benefit Period by a Covered Person for Covered Services.

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

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

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

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

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

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

Prescription Drug Allowed Amount - for Network Pharmacies, the Prescription Drug Allowed Amount means the lesser of the Prescription Drug Negotiated Amount or the Prescription Drug Covered Charges. For non-Network Pharmacies, the Prescription Drug Allowed Amount means the Prescription Drug Covered Charges.

Prescription Drug Benefit Period Deductible - an amount, usually stated in dollars, for which you are responsible each Benefit Period before Medical Mutual will start to provide benefits for a Prescription Order or refill.

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

Prescription Drug Coinsurance Limit - a specified dollar amount of Prescription Drug Coinsurance expense Incurred in a Benefit Period by a Covered person for Prescription Drug benefits.

Prescription Drug Copayment - an amount, usually stated in dollars, for which you are responsible before Medical Mutual 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 Negotiated Amount - the amount the Pharmacy has agreed 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 Pharmacy instead of Medical Mutual contracting directly with the Pharmacy 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 Pharmacy, 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.

Specialty Prescription Drugs - A Prescription Drug that:

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

Provider - a licensed Pharmacy or Physician.

Multi-Language Interpreter Services & Nondiscrimination Notice



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

Spanish

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

Chinese

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

German

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

Arabic

ملحوظة: إذا كنت تتحدث أذكر 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 nínizín: Díí saad bee yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, kojí' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

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

Korean

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

Italian

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

Japanese

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

Dutch

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

Ukrainian

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

Romanian

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

Tagalog

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

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.

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- 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

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