

**PPO Network Comprehensive Major Medical
Health Care Benefit Book**

TABLE OF CONTENTS

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL HEALTH CARE BENEFIT BOOK	1
HOW TO USE YOUR BENEFIT BOOK	2
ELIGIBILITY	3
PPO NETWORK COMPREHENSIVE MAJOR MEDICAL SCHEDULE OF BENEFITS	5
HEALTH CARE BENEFITS	11
Allergy Tests and Treatments	11
Ambulance Services	11
Case Management.....	11
Dental Services for an Accidental Injury	12
Diagnostic Services	12
Drug Abuse and Alcoholism Services.....	12
Drugs and Biologicals	12
Emergency Services	12
Home Health Care Services	13
Hospice Services	13
Inpatient Hospital Services	14
Maternity Services	15
Medical Care	15
Medical Supplies and Equipment	16
Mental Health Care Services	17
Organ and Tissue Transplant Services	18
Outpatient Institutional Services	19
Outpatient Therapy Services	19
Private Duty Nursing Services	20
Routine Services - Please refer to the Schedule of Benefits for Benefit Maximums.....	20
Skilled Nursing Facility Services	21
Surgical Services	21
Temporomandibular Joint Syndrome Services.....	22
EXCLUSIONS	23
GENERAL PROVISIONS	25
How to Apply for Benefits.....	25
How Claims are Paid	25
Filing a Complaint	28
Filing an Appeal - Effective July 1, 2003.....	28
Claim Review	33
Privacy and Confidentiality of Members' Personal Health Information	33
Legal Actions	36
Coordination of Benefits.....	36
Right of Subrogation and Reimbursement.....	38
Changes In Benefits or Provisions.....	38
Termination of Coverage	39
DEFINITIONS	41

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL HEALTH CARE BENEFIT BOOK

This Benefit Book describes the Bowling Green State University (BGSU) Health Care Plan benefits available to you as a participant in the Self Funded Health Benefit Plan (the Plan) offered to you by BGSU. It is subject to the terms and conditions of the BGSU Group Contract. This is not a summary plan description or Plan Document by itself. However, it may be attached to or included with a document prepared by (BGSU) that is called a summary plan description.

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

All persons who meet the following criteria are covered by the BGSU 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 (BGSU) shall have the exclusive right to interpret and apply the terms of this Benefit Book. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Medical Mutual and the Plan Sponsor, subject to any available appeal process.

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

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

Your Benefit Book may be modified by later 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 at the end of this Benefit Book. 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 BGSU Health Care Plan benefits. Please read it carefully.

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

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

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

The **Exclusions** section lists services which are not covered in addition to those listed in the Health Care and Dental 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, how and when your coverage stops and how to obtain coverage if this coverage stops.

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

ELIGIBILITY

Applying for Coverage

Prior to receiving this Benefit Book, you enrolled for individual coverage, individual plus one coverage or family coverage. For coverage, you may have completed a BGSU HealthCare Enrollment & Change Form. There may be occasions when the information on the enrollment form is not enough. The Plan will then request the additional data needed to determine whether you are eligible.

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

Effective Date

Coverage starts at 12:01 a.m. the first of the month following your date of hire. No benefits will be provided for services, supplies or charges Incurred before your Effective Date of coverage.

Eligible Dependents

An Eligible Dependent is:

- the Card Holder's spouse, as defined by Ohio law;
- the Card Holder or spouse's unmarried children, stepchildren, children placed for adoption, legally adopted children, children for whom either the Card Holder or Card Holder's spouse is the Legal Guardian or Custodian or any children who, by court order, must be provided health care coverage by the Card Holder or the Card Holder's spouse. To be considered Eligible Dependents, children's ages must fall within the age limit specified in the Schedule of Benefits, and they must receive over half of their support during the calendar year from the Card Holder unless coverage is being provided under court order.

Eligibility will continue past the age limit for Eligible Dependents who are unmarried and primarily dependent upon the Card Holder for support due to a physical handicap or mental retardation which renders them unable to work. This incapacity must have started before the age limit was reached and must be medically certified by a Physician. You must notify your Plan Sponsor of the Eligible Dependent's desire to continue coverage within 31 days of reaching the limiting age. After a two-year period following the date the Eligible Dependent meets the age limit, the Plan may annually require further proof that the dependence and incapacity continue.

Qualified Medical Child Support Order

In general, a Qualified Medical Child Support Order (QMCSO) is a court order that requires an eligible employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or paternity dispute. A QMCSO may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. This Plan provides benefits according to the requirements of any QMCSO. BGSU will promptly notify affected participants and alternate recipients if a QMCSO is received. BGSU will notify these individuals of its procedures for determining whether medical child support orders are qualified; within a reasonable time after receipt of such order, BGSU will determine whether the order is qualified and notify each affected participant and alternate recipient of its determination.

Once the dependent child is enrolled as an alternate recipient under a QMSCO, 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.

Changes in Coverage

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

A spouse and other dependents who become eligible by reason of marriage will be effective on the first of the month of the qualifying event if a BGSU HealthCare Enrollment & Change Form for their coverage is submitted to the BGSU Benefits Office within 31 days of the marriage. A newborn child is covered from birth. In order to add dependent coverage for a newborn, you must submit a BGSU HealthCare Enrollment & Change Form to the BGSU Benefits Office within 31 days of birth. An adopted child will be covered on the first of the month in which adoptive placement in the home occurred. In order to add dependent coverage for an adopted child, you must submit a BGSU HealthCare Enrollment & Change Form to the BGSU Benefits Office within 31 days of the adoptive placement in the home. Coverage will then continue for the adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

If the BGSU Benefits Office is not notified of the change within 31 days of the event, the Effective Date of your coverage will be determined as specified in the General Eligibility Section. It is important to complete and submit your BGSU HealthCare Enrollment & Change Form promptly. If you do not notify the BGSU Benefits Office within the 31 day period, you will not be able to enroll until the next annual enrollment period.

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

The BGSU Benefits Office is located in Human Resources.

Special Enrollment

If you were eligible to enroll under this Benefit Book and declined coverage because of other coverage and lose the other coverage through termination of employment, termination of the other coverage, termination of employer contributions toward coverage, lay off, or death of or divorce from your spouse, you and your Eligible Dependent(s) will be permitted to enroll during a special enrollment period. Enrollment must be supported by written documentation of the termination of the other coverage (including the effective date of the termination). You must complete a BGSU HealthCare Enrollment & Change Form and submit it to the BGSU Benefits Office within 31 days of the event. 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 BGSU Benefits Office 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.

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL SCHEDULE OF BENEFITS

Benefit Period	Calendar year
Deductible per calendar year	\$150 individual / \$300 individual plus one / \$450 family
Non-PPO Network Deductible per calendar year	\$300 individual / \$600 individual plus one / \$900 family
Blood Deductible	Two pints
Dependent Age Limit	The end of the calendar year of the 23rd birthday
Coinsurance Limit	\$750 individual / \$1,500 individual plus one / \$2,250 family
Non-PPO Network Coinsurance Limit	\$2,250 individual / \$4,500 individual plus one / \$6,750 family

Any amounts applied to your Deductible or Coinsurance Limit will not accumulate towards your Non-PPO Network Deductible or towards your Non-PPO Network Coinsurance Limit.

Any amounts applied to your Non-PPO Network Deductible or Non-PPO Network Coinsurance Limit will not accumulate towards your Deductible or Coinsurance Limit.

Any amount of Coinsurance you pay for Covered Services received from a Non-Contracting Institutional Provider will not accumulate towards the Coinsurance Limit, but will accumulate towards the Non-PPO Network Coinsurance Limits.

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

The following Covered Service is not subject to the calendar year Deductible, Non-PPO Network calendar year Deductible, Coinsurance or Non-PPO Network Coinsurance provisions:

Second surgical opinion services

The following Covered Services are not subject to the calendar year Deductible or Non-PPO Network calendar year Deductible provisions:

Emergency services received in the emergency room

Non-Emergency services received in the emergency room

The following Covered Service is not subject to the calendar year Deductible or Non-PPO Network calendar year Deductible provisions, but is subject to a \$50 Copayment each time services are received:

The Institutional charge for the medical use of the emergency room, excluding any other Institutional charges. Copayment waived if directly admitted to a Hospital.

The following Covered Services are not subject to the Benefit Period Deductible or Coinsurance provisions, when services are received from a PPO Network Provider:

Chemotherapy, including administration of chemotherapy drugs, when received in a Physician's office

Diagnostic Services, including anesthesia, when received in a Physician's office

Medically Necessary Physician office visits and home Physician visits, after a \$20 Copayment

Medical Supplies, including Durable Medical Equipment, when received in a Physician's office

Outpatient Allergy Tests and Treatment, when received in a Physician's office

Radiation Therapy

Routine Immunizations, when received in a Physician's office (refer to the Routine Services section)

Routine Mammogram Services

Routine PAP tests

Routine Physical Examinations, after a \$20 Copayment

Routine Prostate Specific Antigen (PSA) tests

Routine Testing

Therapeutic Injections

Well Child Care office visits, after a \$20 Copayment

Well Child Care services (refer to Benefit Maximums per Covered Persons section)

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

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

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

Organ Transplant Waiting Period

If you Incurred medical expenses, received medical treatment, used Prescription Drugs or were advised by a Physician or Other Professional Provider to receive treatment for Organ Transplant Services at any time during the six (6) month period immediately preceding your Enrollment Date, Medical Mutual will provide benefits for Covered Organ Transplant Services Incurred after twelve (12) months following your Enrollment Date. Your Enrollment Date is your Effective Date or, if earlier, the first day of your waiting period for enrollment.

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

PLAN BENEFIT MAXIMUMS PER COVERED PERSON	
Chiropractic Visits	\$750 per calendar year
Inpatient Drug Abuse and Alcoholism Services	30 days per calendar year
Inpatient Mental Health Care Services	30 days per calendar year
Outpatient Drug Abuse and Alcoholism Services	\$2,500 per calendar year; of which a maximum of \$1,500 may be received from Non-PPO Network Provider
Outpatient Mental Health Care Services	30 visits per calendar year
Outpatient Occupational and Physical Therapy Services	30 visits (combined) per calendar year
Outpatient Speech Therapy Services	20 visits per calendar year
Routine Mammogram Services	Limited to \$85 per mammogram as follows: <ul style="list-style-type: none"> • age 35 to 39; one mammogram • age 40 to 49; one mammogram every 24 rolling months • age 50 and above; one mammogram every 12 rolling months
Routine PAP Test(s)	One test per calendar year
Routine Prostate Specific Antigen (PSA) Test(s)	Age 40 and above; one test every 12 rolling months
Routine Testing	Limited to \$150 per calendar year
Well Child Care Services	\$500, birth to age one; \$150, age one to age nine

MAXIMUM BENEFIT PAYABLE PER LIFETIME PER COVERED PERSON	
For Inpatient Drug Abuse and Alcoholism Services	Two admissions
For all Covered Services	\$2,000,000

COINSURANCE PAYMENTS – CONTRACTING PROVIDERS (1)			
TYPE OF SERVICE	For Covered Services received from a PPO Network Provider	For Covered Services received from a Non-PPO Network Provider	
		Before your Non-PPO Network Coinsurance Limit has been Reached	After your Non-PPO Network Coinsurance Limit has been Reached
YOU PAY THE FOLLOWING			
BEFORE YOUR COINSURANCE LIMIT HAS BEEN REACHED			
Emergency Accident Services	10% of Lesser Amount	10% of Lesser Amount	Does not apply
Emergency Medical - Emergency Room the Institutional charge for the use of the emergency room, excluding any other charges	\$50 Copayment/visit, waived if admitted, then 10% of Lesser Amount	\$50 Copayment/visit, waived if admitted, then 10% of Lesser Amount	Does not apply
Emergency Medical Services - all other related Institutional and Professional charges	10% of Lesser Amount	10% of Lesser Amount	Does not apply
Non-Emergency - Emergency Room the Institutional charge for the use of the emergency room, excluding any other charges	\$50 Copayment/visit, waived if admitted, then 10% of Lesser Amount	\$50 Copayment/visit, waived if admitted, then 10% of Lesser Amount	Does not apply
Non-Emergency Services - all other related Institutional and Professional charges	10% of Lesser Amount	10% of Lesser Amount	Does not apply
Outpatient Mental Health Care, Drug Abuse and Alcoholism Services (2)	20% of Lesser Amount	50% of Lesser Amount	Does not apply
All Other Covered Services	10% of Lesser Amount	30% of Lesser Amount	Does not apply
AFTER YOUR COINSURANCE LIMIT HAS BEEN REACHED			
Emergency Accident Services	0% of Lesser Amount	0% of Lesser Amount	0% of Lesser Amount
Emergency Medical - Emergency Room the Institutional charge for the use of the emergency room, excluding any other charges	\$50 Copayment/visit, waived if admitted, then 0% of Lesser Amount	\$50 Copayment/visit, waived if admitted, then 0% of Lesser Amount	\$50 Copayment/visit, waived if admitted, then 0% of Lesser Amount
Emergency Medical Services - all other related Institutional and Professional charges	0% of Lesser Amount	0% of Lesser Amount	0% of Lesser Amount
Non-Emergency - Emergency Room the Institutional charge for the use of the emergency room, excluding any other charges	\$50 Copayment/visit, waived if admitted, then 0% of Lesser Amount	\$50 Copayment/visit, waived if admitted, then 10% of Lesser Amount	\$50 Copayment/visit, waived if admitted, then 0% of Lesser Amount
Non-Emergency Services - all other related Institutional and Professional charges	0% of Lesser Amount	10% of Lesser Amount	0% of Lesser Amount
Outpatient Mental Health Care, Drug Abuse and Alcoholism Services (2)	20% of Lesser Amount	50% of Lesser Amount	50% of Lesser Amount
All Other Covered Services	0% of Lesser Amount	30% of Lesser Amount	0% of Lesser Amount

COINSURANCE PAYMENTS - NON-CONTRACTING PROVIDERS (3) For Covered Services received from a Non-Contracting Hospital, Skilled Nursing Facility, Home Health Care Agency or Hospice Facility		
TYPE OF SERVICE	Before your Non-PPO Network Coinsurance Limit has been Reached	After your Non-PPO Network Coinsurance Limit has been Reached
YOU PAY THE FOLLOWING		
BEFORE YOUR COINSURANCE LIMIT HAS BEEN REACHED		
Emergency Accident Services	10% of Covered Charges	Does not apply
Emergency Medical - Emergency Room the Institutional charge for the use of the emergency room, excluding any other charges	\$50 Copayment/visit, waived if admitted, then 10% of Covered Charges	Does not apply
Emergency Medical Services - all other related Institutional and Professional charges	10% of Covered Charges	Does not apply
Non-Emergency - Emergency Room the Institutional charge for the use of the emergency room, excluding any other charges	\$50 Copayment/visit, waived if admitted, then 10% of Covered Charges	Does not apply
Non-Emergency Services - all other related Institutional and Professional charges	10% of Covered Charges	Does not apply
Outpatient Mental Health Care, Drug Abuse and Alcoholism Services (2) (4)	50% of Covered Charges	Does not apply
All Other Covered Services (5)	30% of Covered Charges	Does not apply
AFTER YOUR COINSURANCE LIMIT HAS BEEN REACHED		
Emergency Accident Services	0% of Covered Charges	0% of Covered Charges
Emergency Medical - Emergency Room the Institutional charge for the use of the emergency room, excluding any other charges	\$50 Copayment/visit, waived if admitted, then 0% of Covered Charges	\$50 Copayment/visit, waived if admitted, then 0% of Covered Charges
Emergency Medical Services - all other related Institutional and Professional charges	0% of Covered Charges	0% of Covered Charges
Non-Emergency - Emergency Room the Institutional charge for the use of the emergency room, excluding any other charges	\$50 Copayment/visit, waived if admitted, then 0% of Covered Charges	\$50 Copayment/visit, waived if admitted, then 0% of Covered Charges
Non-Emergency Services - all other related Institutional and Professional charges	0% of Covered Charges	0% of Covered Charges
Outpatient Mental Health Care, Drug Abuse and Alcoholism Services (2) (4)	50% of Covered Charges	50% of Covered Charges
All Other Covered Services (5)	30% of Covered Charges	0% of Covered Charges

Notes:

Please call the Customer Service telephone number on the back of your Identification Card to determine the status of a Provider.

1. Medical Mutual has agreed to make payment directly to Contracting Institutional Providers and Participating Physicians and Other Professional Providers for Covered Services. Please refer to the General Provisions for additional information.
2. There is no Coinsurance Limit or Non-PPO Network Coinsurance Limit with respect to Outpatient Mental Health Care, Drug Abuse and Alcoholism Services. Any amount of Coinsurance or Non-PPO Network Coinsurance you pay for Outpatient Mental Health Care, Drug Abuse and Alcoholism Covered Services will not accumulate towards the Coinsurance Limit or the Non-PPO Network Coinsurance Limit.

3. Medical Mutual reserves the right to make payment directly to you for Covered Services performed by Non-Contracting Providers. When this occurs, you must pay the Provider and neither Medical Mutual nor the Plan are legally obligated to pay any additional amounts. You may be responsible for Excess Charges. Please refer to the General Provisions for additional information.
4. No benefit is provided for Outpatient Mental Health Care, Drug Abuse and Alcoholism Services received from a Non-Contracting Other Facility Provider which is not a Home Health Care Agency. You are responsible for 100% of the Billed Charges.
5. No benefit is provided for services received from a Non-Contracting Other Facility Provider (i.e., Ambulatory Surgical Facility) which is not a Skilled Nursing Facility, Home Health Care Agency or Hospice Facility. You are responsible for 100% of the Billed Charges.

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

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

HEALTH CARE BENEFITS

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

Please refer to the Pre-Authorization of Non-PPO Network Benefits section for information regarding services received from Non-PPO Network Providers.

Allergy Tests and Treatments

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

Ambulance Services

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

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

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

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

Case Management

Case management is an economical, common sense approach to managing health care benefits. Medical Mutual's case management staff evaluates opportunities to cover cost-effective alternatives to the patient's current health care needs. Case management has proven to be very effective with catastrophic cases, long-term care, psychiatric and substance abuse treatment and outpatient cardiac rehabilitation therapy. In such instances, benefits not expressly covered in this Benefit Book may be approved. All case management programs are voluntary for the patient.

Phase II outpatient cardiac rehabilitation therapy services which are Medically Necessary as a result of a cardiac event may be covered through case management if certain criteria is met. This criteria includes myocardial infarction or history of myocardial infarction, percutaneous transluminal cardiac angioplasty, coronary artery bypass graft, valve replacement, organ transplant (within six months of receiving the transplant), a history of three or more admissions that include a cardiac diagnosis (within a one year period). The therapy services must be reasonably expected to result in a significant improvement in the level of cardiac functioning.

Coverage for these services must be approved in advance and in writing by Medical Mutual.

To learn more about these services, you may contact Medical Mutual's case management staff.

Dental Services for an Accidental Injury

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

Diagnostic Services

A diagnostic service is a test or procedure performed when you have specific symptoms, to detect or monitor your Condition. It must be ordered by a Physician or Other Professional Provider. Covered diagnostic services include but are not limited to the following:

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

Certain Diagnostic Services require your Physician or Other Professional Provider to receive prior authorization and approval from Medical Mutual. In the event of an emergency, the service can be provided and reviewed retroactively by Medical Mutual for Medical Necessity.

Drug Abuse and Alcoholism Services

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

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

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

Drugs and Biologicals

You are covered for Prescription Drugs and biologicals that cannot be self-administered and are furnished as part of a Physician's professional service in the course of the diagnosis or treatment of a Condition. Drugs and biologicals must be administered by a Physician or Other Professional Provider while an Inpatient or during an Outpatient procedure. Prescription Drugs which are self-administered are covered under the BGSU prescription drug program which is not administered by Medical Mutual.

Emergency Services

Emergency services means:

- a medical screening examination as required by Federal Law that is within the capability of the Emergency Department of the Hospital, including ancillary services routinely available to the Emergency Department to evaluate an emergency medical Condition; and

- further medical examination and treatment that are required to stabilize an emergency medical Condition and within the capabilities of the staff and facilities available at the Hospital, including any trauma or burn center at the Hospital.

You are Covered for the treatment of a sudden and serious accidental injury or illness if, without this immediate care, a prudent layperson with average knowledge of health and medicine would reasonably expect the Condition could:

- permanently endanger his or her health, or with respect to a pregnant woman, the health of the woman or her unborn child;
- cause other serious Conditions;
- seriously impair your body functions; or
- cause serious and permanent damage to any part of the body or bodily organs.

These policies also apply to medical treatment received as a result of a 911 call response.

Home Health Care Services

The following are Covered Services when you **receive them in your home, from a Hospital or a Home Health Care Agency**:

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

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

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

Hospice Services

Hospice services consist of health care services provided to a terminally ill Covered Person. **Hospice services must be provided through a freestanding Hospice Facility or a hospice program sponsored by a Hospital or Home Health Care Agency.** Hospice services may be received by the Covered Person in a private residence.

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

The following Covered Services are considered hospice services:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- Prescription Drugs; limited to a two-week supply per Prescription Order or refill (These Prescription Drugs must be required in order to relieve the symptoms of a Condition, or to provide supportive care.);
- oxygen and its administration;
- medical social services, such as the counseling of patients;

- home health aide visits when you are also receiving covered nursing or therapy services;
- acute Inpatient hospice services;
- respite care;
- dietary guidance; counseling and training needed for a proper dietary program;
- durable medical equipment; and
- bereavement counseling for family members.

A treatment plan must be developed and submitted to Medical Mutual by the Covered Person's Physician and the Provider of the hospice services. The treatment plan must be approved by Medical Mutual.

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

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

<h2>Inpatient Hospital Services</h2>

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

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

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

- a semiprivate room or ward;
- a private room, when Medically Necessary; if you request a private room, the Plan will provide benefits only for the Hospital's average semiprivate room rate; and
- a bed in a special care unit approved by Medical Mutual. The unit must have facilities, equipment and supportive services for the intensive care of critically ill patients.

Covered ancillary Hospital services include but are not limited to:

- operating, delivery and treatment rooms and equipment;
- Prescription Drugs;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing;
- anesthesia, anesthesia supplies and services;
- oxygen and other gases;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services;
- therapy services, including phase I for cardiac rehabilitation; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

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

- gowns and slippers;
- shampoo, toothpaste, body lotions and hygiene packets;

- take-home drugs;
- telephone and television; and
- guest meals or gourmet menus.

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

- diagnostic services;
- Custodial Care;
- rest care;
- environmental change; or
- physical therapy.

Maternity Services

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

This plan complies with Federal law that prohibits:

- Restricting benefits of any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or
- Requiring a provider to obtain authorization from the Plan for prescribing a length of stay within those time periods.
- A Card Holder or Card Holder's Eligible Dependent may not be charged a higher Copayment or offered fewer benefits.

A Card Holder or Card Holder's Eligible Dependent may voluntarily leave the hospital early.

Medical Care

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

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

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

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

Staff consultations required by Hospital rules are not covered.

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

Newborn Exam - Refer to the Eligibility section for information about enrolling your newborn for coverage. Your coverage will include the Inpatient Medical Care Visits to examine a newborn.

Outpatient Medical Care - Office visits and consultations to examine, diagnose and treat a Condition are Covered Services.

Medical Supplies and Equipment

This section describes supplies and equipment that are covered when prescribed by your Physician. These supplies and equipment must serve a specific therapeutic purpose in the treatment of a Condition.

Medical and Surgical Supplies - Disposable supplies which serve a specific therapeutic purpose are covered. These include, but are not limited to Jobst stockings, surgical stockings, elastic stockings, syringes, needles, oxygen, surgical dressings and other similar items. Items usually stocked in the home for general use such as elastic bandages, thermometers, and corn and bunion pads are not covered.

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

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

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

Covered DME includes but is not limited to:

- respirators;
- home dialysis equipment;
- wheelchairs;
- hospital beds; and
- crutches.

Non-covered equipment includes but is not limited to:

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

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

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

Non-covered devices include but are not limited to:

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

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

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

Your Physician may be required to certify Medical Necessity for the appliance.

Covered prosthetic appliances include but are not limited to the following:

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

Non-covered appliances include but are not limited to:

- dentures, unless as a necessary part of a covered prosthesis;
- dental appliances;
- eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye;
- replacement of cataract lenses unless needed because of a lens prescription change;
- taxes included in the purchase of a covered prosthetic appliance; and
- wigs and hair pieces.

Mental Health Care Services

The following are Covered Services for the treatment of Mental Illness:

- individual and group psychotherapy;
- electroshock therapy and related anesthesia only if given in a Hospital or Psychiatric Hospital;
- psychological testing;
- family counseling: counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Benefit Book. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient.

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

Services for Mental Illness which cannot be treated are not covered. However, services to determine if the Mental Illness can be treated are covered. Services for mental deficiency or retardation, other than those necessary to evaluate or diagnose mental deficiency or retardation, are not covered. Services for the treatment of attention deficit disorder are covered.

Organ and Tissue Transplant Services

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

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

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

Organ Transplant Pre-Certification - In order for an organ transplant to be a Covered Service, the proposed course of treatment must be pre-certified and approved by Medical Mutual. **No benefits will be provided for organ transplant services which have not been pre-certified.**

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

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

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

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

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

Medical Mutual does not provide organ/tissue transplant benefits for services, supplies or Charges:

- which are not furnished through a course of treatment which has been approved by Medical Mutual;
- which are not provided during a transplant benefit period;
- for other than a legally obtained human organ/tissue; or
- for travel time and the travel-related expenses of a Provider.

Outpatient Institutional Services

The Covered Services listed below are covered when services are performed in an Outpatient setting, except as specified. **Please call the Customer Service telephone number on the back of your Identification Card for information on eligible providers.**

Covered Institutional services include but are not limited to:

- operating, delivery and treatment rooms and equipment;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing;
- anesthesia, anesthesia supplies and services; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

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

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

Outpatient Therapy Services

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

Cardiac Rehabilitation Services - Please refer to the "CASE MANAGEMENT" section for information on coverage for Outpatient cardiac rehabilitation services.

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

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

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

Hyperbaric Therapy - The provision of pressurized oxygen for treatment purposes. These services must be provided by a Hospital. Treatment for these services must be Medically Necessary and will include, but are not limited to: chronic non-healing wounds

- non-healing diabetic wounds of the lower extremities
- crash injuries (when loss of function, limb or life is threatened)
- decompression sickness
- gas embolism
- chronic osteomyelitis
- compromised skin grafts and flaps

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

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

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

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

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

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

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

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

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

Private Duty Nursing Services

The services of a registered nurse, licensed vocational nurse or licensed practical nurse when ordered by a Physician are covered. These services include skilled nursing services received in a patient's home.

Private duty nursing services include services that Medical Mutual decides are of such a degree of complexity that the Provider's regular nursing staff cannot perform them. When private duty nursing services are received in your home, nurse's notes must be sent in with your claim.

All private duty nursing services must be certified initially and every 30 days thereafter by your Physician for Medical Necessity.

Private duty nursing services do not include care which is primarily nonmedical or custodial in nature such as bathing, exercising or feeding. Also, the Plan does not cover services provided by a nurse who usually lives in your home or is a member of your Immediate Family.

Routine Services - Please refer to the Schedule of Benefits for Benefit Maximums

Immunizations - The following immunizations are covered for Covered Persons over the age of nine:

- hepatitis B vaccine;
- measles-mumps-rubella vaccine (MMR);
- meningococcal polysaccharide vaccine;
- rabies vaccine; and
- tetanus toxoid.

Routine Gynecological Services - The following services are covered:

- mammogram services; and
- PAP tests, limited to laboratory Charges only.

Routine Physical Examinations - Routine physical examinations are covered.

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

Routine Testing - All routine laboratory, x-ray, diagnostic medical services and endoscopic procedures are covered.

Routine Venipuncture - Routine venipuncture is a Covered Service.

Well Child Supervision Services - Regardless of Medical Necessity, coverage for well child supervision services will be provided for Eligible Dependent children under the age of nine.

Well child supervision services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination and developmental assessment. This review also includes anticipatory guidance, laboratory tests, routine venipuncture and appropriate immunizations.

Skilled Nursing Facility Services

The benefits available to an Inpatient of a Hospital listed under the Inpatient Hospital Services section are also available to an Inpatient of a Skilled Nursing Facility. These services must be Skilled Care and authorized and provided according to your Physician's plan of treatment. Your Physician must certify initially and every two weeks, thereafter, that you are receiving Skilled Care and not Custodial Care.

No benefits are provided:

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

Surgical Services

Surgery - Coverage is provided for **Medically Necessary** Surgery, except as specified. In addition, coverage is provided for the following specified services:

- sterilization, regardless of Medical Necessity;
- maxillary or mandibular frenectomy;
- mandibular staple implant. This is not a Covered Service when performed to prepare the mouth for prosthetics;
- Surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
- Surgery to improve a functional deficiency; and
- Therapeutic abortions

Diagnostic Surgical Procedures - Coverage is provided for surgical procedures to diagnose your Condition while you are in the Hospital. If you are an Inpatient for fewer than four days, only the diagnostic surgical procedure is covered. If you are hospitalized four days or more, the diagnostic surgical procedure and Medical Care visits except for the day the surgical procedure was performed are covered.

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

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

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

Oral Surgery - Coverage is provided for oral Surgery services. Benefits consist of operative and cutting procedures; these must be performed for the treatment of diseases and injuries of the jaw.

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

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

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

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

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

Reconstructive Surgery Following Mastectomy - When a person covered for benefits under this Benefit Book who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same Coinsurance and Deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications in all stages of mastectomy, including lymphedema.

If you have any questions about your benefits under this plan, please call the Customer Service telephone number on the back of your Identification Card or contact the BGSU Benefits Office.

Temporomandibular Joint Syndrome Services

Temporomandibular Joint Syndrome (TMJ) is a Condition which causes pain or dysfunction in the temporomandibular joint and/or the temporal region. This syndrome may include limited motion of the jaw caused by improper occlusal alignment. Occlusal refers to the fit of the teeth as the two jaws meet.

The Covered Services listed below are covered when Medically Necessary for the diagnosis and treatment of TMJ:

- diagnostic services;
- physical therapy;
- office visits; and
- orthotic appliances.

EXCLUSIONS

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

1. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
2. Not performed within the scope of the Provider's license.
3. Received from other than a Provider.
4. For Experimental or Investigational Drugs, Devices, Medical Treatments or Procedures.
5. To the extent that governmental units or their agencies provide benefits.
6. For a Condition that occurs as a result of any act of war.
7. For which you have no legal obligation to pay in the absence of this or like coverage.
8. Received from a member of your Immediate Family.
9. Incurred after you stop being a Covered Person except as specified in the Benefits After Termination of Coverage section.
10. For the following:
 - physical examinations or services required by an insurance company to obtain insurance;
 - physical examinations or services required by a governmental agency such as the FAA and DOT;
 - physical examinations or services required by an employer in order to begin or to continue working;
 - premarital examinations;
 - screening examinations, except as specified;
 - X-ray examinations made without film; or
 - routine or annual physical examinations for Covered Persons nine years of age or older.
11. For a Condition occurring in the course of employment 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.
12. 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.
13. Received in a military facility for a military service related Condition.
14. For Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form.
15. For educational, vocational or training purposes except those required for the treatment of diabetes.
16. For treatment of Conditions related to an autistic disease of childhood, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.
17. For topical anesthetics.
18. For anoscopy, except as specified.
19. For arch supports and other foot care or foot support devices only to improve comfort or appearance which include, but are not limited to, care for flatfeet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails.
20. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss or for weight loss through Surgery unless your weight is at least twice the ideal amount, except as specified.

21. For marital counseling.
22. For the medical treatment of sexual problems not caused by a biological Condition.
23. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
24. For birth control devices which include, but are not limited to, IUD's and diaphragms.
25. For reverse sterilization.
26. For artificial insemination or in vitro fertilization.
27. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
28. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
29. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.
30. For personal hygiene and convenience items.
31. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except those for aphakic patients and soft lenses or sclera shells for use as corneal bandages.
32. For any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).
33. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
34. For immunizations, other than those specified as covered in the Routine Services section of this Benefit Book.
35. For hypnosis, acupuncture and other non-covered alternative therapies.
36. For telephone consultations, missed appointments, completion of claim forms or copies of medical records.
37. For fraudulent or misrepresented claims.
38. For blood which is available without charge. For blood storage services provided by other than a Hospital.
39. For Prescription Drugs, except as specified.
40. For elective and non-therapeutic abortions.
41. For Mental Illness services which cannot be treated.
42. For developmental delay of speech.
43. For Inpatient Private Duty Nursing Services.
44. For non-covered services or services specifically excluded in the text of this Benefit Book.

GENERAL PROVISIONS

How to Apply for Benefits

Notice of Claim; Claim Forms

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

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

Proof of Loss

Proof of Loss is a claim for payment of health care services which has been submitted to Medical Mutual for processing with sufficient documentation to determine whether Covered Services have been provided to you. Medical Mutual must receive a completed claim with the correct information. Medical Mutual may require Provider's notes or other medical records before Proof of Loss is considered sufficient to determine benefit coverage.

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

How Claims are Paid

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

Benefit Period Deductible

Each calendar year, you must pay the dollar amount as specified in the Schedule of Benefits as the Deductible before the Plan will begin to provide benefits. This is the amount of expense that must be Incurred and paid by you for Covered Services before the Plan starts to provide benefits. Any benefit that has an associated Copayment may or may not be subject to the Deductible. If a benefit is subject to a Deductible, only expenses for Covered Services under that benefit will satisfy the Deductible. To satisfy your Deductible, the Plan records must show that you have Incurred claims totaling the specified dollar amount, so submit copies of all your bills for Covered Services. Your Deductible accumulations do not necessarily occur in the same order that you receive services, but in the order in which Medical Mutual receives and processes your claims. Copayments will not apply to the Deductible. Deductibles and Copayments do not apply to the Coinsurance Limit.

The Schedule of Benefits specifies an individual Deductible, an individual plus one Deductible and a family Deductible. The individual Deductible is the amount each Covered Person must pay. The individual plus one Deductible is the total amount a Covered Person and an Eligible Dependent must pay. The total amount the family must pay is limited to the family Deductible.

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

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

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

Coinsurance

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

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

Copayments

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

Schedule of Benefits

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

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

Your Financial Responsibilities

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

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

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

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

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

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

Provider Status and Direction of Payment

Medical Mutual has agreed to make payment directly to Contracting Institutional Providers and Participating Physicians and Other Professional Providers for Covered Services. Except for Copayments that may apply, you will not be required to pay any amount of your financial responsibility for Covered Services at the time they are rendered by these Providers.

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

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

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

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

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

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

Pre-Authorization of Non-PPO Network Benefits

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

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

- the proposed treatment plan for the Covered Services;
- the name and location of the proposed Non-PPO Network Provider;

- copies of your medical records, including diagnostic reports; and
- an explanation of why the Covered Services cannot be provided by a PPO Network Provider.

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

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

Explanation of Benefits

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

Time of Payment of Claims

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

Filing a Complaint

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on 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 Group Contract, 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 - Effective July 1, 2003

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

To file an appeal, please call the Customer Service telephone number on your identification card or write a letter with the following information: Card Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or records, X-rays or photographs you would like considered in the appeal. Send or fax the letter to:

Medical Mutual
Member Appeals Unit
MZ: 01-1B-4809
P.O. Box 94580
Cleveland, Ohio 44101-4580
FAX: (216) 687-7990

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

First Level Mandatory Appeal

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

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

Under the appeal process there will be a full and fair review of the claim. The internal appeal process is a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations of Medical Necessity that are based in whole or in part on a medical judgment, are made by health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

You may submit written comments, documents, records and other information relating to the claim being appealed. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that you are appealing.

The appeal procedures are as follows:

- You, your authorized representative or your Provider may request an appeal for urgent care. Urgent care claim appeals are typically those claims for medical care or treatment where withholding immediate treatment could seriously jeopardize the life or health of a patient or a patient's unborn child, or could affect the ability of the patient to regain maximum functions. The appeal must be decided within 72 hours of the request.
- You, your authorized representative or your Provider may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining medical care for approval of a benefit, as it relates to the terms of the plan Benefit Book. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of denial.
- You, your authorized representative or your Provider may request a post-service claim appeal. Post-service claim appeals are those requested for payment or reimbursement of the cost for medical care that has already been provided. As with pre-service claims, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of the denial.

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

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based.
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, then that information will be provided free of charge upon written request;
- if the claim was denied based on a Medical Necessity or Experimental treatment or similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be provided free of charge upon request;

- upon specific written request from you, provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination

Voluntary Second Level Appeal

If your first level mandatory appeal is denied, and you do not qualify for review by the Ohio Department of Insurance or for an External Review by an external committee, as described in the following sections, then you have the option of a voluntary second level appeal by Medical Mutual. You are under no obligation to request this second appeal with Medical Mutual and you may instead request review by the BGSU Insurance Appeals Committee, or, if you meet the criteria for the Insurance Commissioner review or external review, by the Insurance Commissioner or the external review committee. The voluntary second level of appeal may be requested at the conclusion of the first level mandatory appeal. The request for the voluntary second level of appeal must be received by Medical Mutual within 60 days from the receipt of the first appeal decision.

All requests for a voluntary secondary appeal may be made by calling or writing to Customer Service. You may submit additional written comments, documents, records, X-rays, photographs and other information relating to the claim being appealed.

Medical Mutual will complete its review of the voluntary second level appeal within 30 days from receipt of the request.

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

BGSU Internal Review Procedure

Once you have exhausted all the review procedures with Medical Mutual, you may appeal to the BGSU Insurance Appeals Committee, but you are not compelled to do so. If you wish to request such a review, you must file within 60 days of the last denial of your claim by MMO under the review process described in the preceding section of this summary. Any decision that the Committee makes, including the decision not to hear your appeal, may not be further appealed within MMO or BGSU. However, if your claim is denied because there is an issue of whether the claim is for a covered service or item, you have the right under Ohio law to appeal to the Ohio Insurance Commissioner. Further, if your claim is denied on the basis of not being medically necessary or you have a terminal condition and your doctor has recommended a procedure that is not covered, you have the right to request an external review. The process for review by the Insurance Commissioner or an external committee is described in the following sections of this summary.

In order to appeal to the BGSU Insurance Appeals Committee, you must meet the following conditions:

1. As noted above, you must have utilized the MMO mandatory review and appeal. This Committee may only be appealed to after MMO has denied your claim.
2. You must include the reasons(s) for the appeal and include any relevant documents, which may be new documentation not previously submitted in any earlier review.
3. You must consent to have Medical Mutual and your medical providers release to the BGSU Benefit Office and to the Committee all correspondence or other material relating to the claim. It is the policy of the Committee to have the Benefits Office receive the material from MMO and delete all identifiers that would disclose your identity before releasing the material to the Committee so that the review can be without bias.

The Committee will meet within 30 days of your appeal to read and discuss the appeal. Additional information may be requested from you, your medical providers, Medical Mutual, or the Benefits Office by the Committee. Please note, your consent form will be worded to allow for this additional information; only information related to the claim presented will be requested.

Within 90 days of the appeal being filed, a hearing may be held if the Committee in its sole discretion deems such hearing necessary. The appellant may attend or send a representative to the hearing. Once the Committee makes its decision, the Committee will report its decision to the Benefits Office, which will then notify you.

You should note that the Committee may approve part of your claim and deny part; its decisions do not have to be all or nothing. Further, any claim that is approved will be subject to any deductibles or co-pays, or other terms and conditions of the Plan that are imposed with respect to that type claim. If the Committee approves your claim, the Benefits Office will notify Medical Mutual to pay your claim.

If your claim is denied, you will be notified and that notice will provide the reasons for the denial.

Your Right to an Independent Review

If Medical Mutual denied, reduced or terminated coverage for a health care benefit because Medical Mutual determined that the benefit was not covered under your Benefit Book, you have the right to request a review by the Ohio Department of Insurance. In Ohio, you may contact the Ohio Department of Insurance at the following address:

Ohio Department of Insurance
Consumer Services Division
2100 Stella Court
Columbus, Ohio 43215-1067

If the Ohio Department of Insurance reviews your case and cannot make a determination because it requires resolution of a medical issue, the Department will notify Medical Mutual of the need to offer you an external review. If the Department of Insurance reviews your case and determines that the health service is a covered benefit, Medical Mutual must either cover the service or allow you the opportunity of an external review.

External Review Process

In accordance with state law, Medical Mutual has also established an external review process to examine coverage decisions under certain circumstances. You may be eligible to have a decision reviewed by the external review process if you meet the following criteria:

1. Medical Mutual has denied, reduced, or terminated coverage for what would be a covered health care service except for the fact that Medical Mutual determined that the service is not Medically Necessary;
2. the proposed service, plus any ancillary services and follow-up care, will cost you \$500 or more if it is not covered, except in the case of an expedited review; and
3. you have exhausted the internal appeal process.

You are NOT entitled to an external review if:

1. The Ohio Department of Insurance determined that the health care service is not a Covered Service under your Benefit Book; or
2. you have already had an external review for the same adverse determination and no new pertinent clinical information has been submitted.

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to Medical Mutual's Member Appeals Unit at the address listed above. A request for a standard appeal for external review must be accompanied by written certification from your Provider that the proposed service, plus any ancillary services and follow-up care, will cost you \$500 or more if the proposed service is not covered by Medical Mutual. Further, the request must be filed within 60 days of receiving the Ohio Department of Insurance Notice if you had previously requested review by the superintendent of insurance to determine that the service was covered.

A written decision will be given within 30 days after you have submitted the request for external reviews. This written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. Medical Mutual will then provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Benefit Book.

Expedited Review Process

You or your authorized representative may request an expedited review of your appeal.

For an expedited review, your Provider must certify that your Condition could, without immediate medical attention, result in any of the following:

1. Place your life or health in serious jeopardy, or with respect to a pregnant woman, place the health of her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

An expedited review request must be made in writing. However, if you have a condition that requires an expedited review, the review may be requested orally or electronically with a written confirmation not later than five days after the request is submitted. A request for an expedited external review should be made by contacting the Care Management Department at the number on the back of your identification card. It can be made by you or your Provider. Your Provider may not, however, request an external review without your prior written consent.

External reviews will be conducted by independent review organizations accredited by the Ohio Department of Insurance. You will not be required to pay for any part of the cost of the external review. Medical Mutual is required by law to provide to the independent review organization conducting the review, a copy of the records that are relevant to your medical Condition and the external review.

In the case of an expedited review, the review panel will issue a written decision within three calendar days after you have submitted the request, with a possibility of extending to five calendar days with good cause. As with the non-expedited review, this written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. Medical Mutual will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Benefit Book.

External Review Process for Terminal Conditions

If you have a terminal Condition, you are eligible to have an external review if you meet all of the following criteria:

1. you have a terminal Condition that, according to the current diagnosis of your Physician, has a high probability of causing death within two years; and
2. your Physician certifies that one of the of the following situations applies to your terminal Condition;
 - a. standard therapies have not been effective in improving your Condition;
 - b. standard therapies are not medically appropriate for you;
 - c. no standard therapy, covered by Medical Mutual, is more beneficial than a therapy recommended by your Physician or requested by you; and
3. your Physician has recommended a drug, device, procedure, or other therapy that your Physician certifies, in writing, is likely to be more beneficial to you, in the Physician's opinion, than standard therapies, or you have requested a therapy found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same Condition; and
4. you have been denied coverage by Medical Mutual for the drug, device, procedure or other recommended or requested therapy and have exhausted all internal appeals; and
5. the drug, device, procedure or other recommended or requested therapy would be a Covered Service except for Medical Mutual determination that the drug, device, procedure or other therapy is Experimental or Investigational.

You must request the review in writing. If your Physician determines that the therapy would be significantly less effective if not started immediately, your request may be oral or by electronic means, but you will need to submit written confirmation of your request within 5 days of your oral or electronic request. You must make your request within 60 days of receiving notice from the Ohio Department of Insurance that making a determination of coverage requires resolution of a medical issue. You will not be required to pay for any part of the cost of the external review. As described above for an external review, your appeal may be handled on a non-expedited or an expedited basis. Your appeal request will be considered non-expedited unless you request that it be treated as expedited. For an expedited appeal, your medical provider (e.g., physician) must certify that the requested or recommended therapy would be significantly less effective if not promptly initiated. If you request and qualify for an expedited review, the review panel will issue a written decision within three calendar days after you have

submitted the request, with a possibility of extending up to four additional calendar days for good cause. If you have a non-expedited review, the review panel will issue a written decision within 30 days after you have submitted your request. The written decision, whether in an expedited or non-expedited review, will include a description of your condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. Medical Mutual will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Benefit Book.

Claim Review

Consent to Release Medical Information - Denial of Coverage

You consent to the release of medical information to Medical Mutual when you enroll and/or sign an 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.

Physical Examination

Medical Mutual may require that you have one or more physical examinations at its expense. These examinations will help to determine what benefits will be covered, especially when there are questions concerning services you have previously received and for which you have submitted claims. These examinations will not have any effect on your status as a Covered Person or your eligibility.

Privacy and Confidentiality of Members' Personal Health Information

This section contains Medical Mutual and the Plan's Privacy Notice. The measures that Medical Mutual and the Plan have put in place to protect your personal health information apply to oral, written and electronic information.

IMPORTANT NOTICE TO ALL INSUREDS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Privacy Is Important to Us

Medical Mutual and the Plan have always been committed to protecting the information you share with us and is required by law to maintain the privacy of your protected health information. Medical Mutual holds its employees and consultants to strict policies and procedures protecting your information. All employees must sign confidentiality agreements. In addition, Medical Mutual employs various technologies to prevent unauthorized access to data. This Privacy Notice will explain the type of information we collect, how we use that information, how we protect that information, your rights as they relate to your information, and our legal duties and privacy practices.

What Information We Collect

Medical Mutual and the Plan understand your concerns regarding the confidentiality of information you share with us. We collect information from you on applications and other transactions with us. This information can include your name, address and Social Security number. Under certain conditions we may also ask you and your Eligible Dependents for medical history information. We also have access to your information through claims submitted to Medical Mutual from healthcare providers, information provided by your employer if your coverage is through a group contract and from your agent.

How We Use and Disclose Your Information

We are permitted by law to use your information for certain purposes including healthcare payment and healthcare operations. Examples of how we may use and disclose your information include but are not limited to:

Payment: Medical Mutual and the Plan may use or disclose your information to pay claims for Covered Services or to provide eligibility information to your Physician when you receive treatment.

Healthcare Operations: Medical Mutual and the Plan may use or disclose your information for activities like (1) underwriting, premium rating or other activities relating to the creation or renewal of a health insurance contract; (2) quality assessment and improvement activities such as peer review and credentialing of providers; (3) care and disease management activities; and (4) data and information systems management.

As Required by Law: Medical Mutual and the Plan must allow the U.S. Department of Health and Human Services access to audit its records. In addition, Medical Mutual and the Plan may be required to release your information to comply with other laws:

- To comply with legal proceedings, such as court orders or administrative orders or subpoenas
- To perform mandatory licensing, regulatory/compliance reporting
- To law enforcement officials for limited law enforcement purposes
- To federal officials for lawful intelligence, counterintelligence and other national security purposes
- To public health authorities for public health purposes
- To comply with workers' compensation and other similar programs established by law that provide for benefits for work-related injuries or illness without regard to fault

To Business Associates: Medical Mutual and the Plan may disclose your information to third parties that it hires to assist in the administration of your benefits. These third parties are called business associates, and they must agree in writing to protect and maintain the confidentiality and security of your information. Examples of business associates are the Physicians who do medical reviews and our brokers who service your policy.

To Plan Sponsors: If you receive insurance benefits through a group plan, Medical Mutual and the Plan may disclose to your Plan Sponsor, in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. Medical Mutual and the Plan may also disclose to your Plan Sponsor the fact that you are enrolled in, or disenrolled from, the Plan. Medical Mutual and the Plan may disclose your medical information to the Plan Sponsor for plan administrative functions that the Plan Sponsor provides to the Plan, if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your medical information. The Plan Sponsor must also agree not to use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor.

Other Uses and Disclosures: Other disclosures that Medical Mutual and the Plan may make:

- To your personal representative appointed by you or designated by law
- To appropriate military authorities, if you are a member of the armed forces
- To a family member, friend or other person for the purpose of helping you with your healthcare or healthcare payment if you are in an emergency situation and you cannot give your agreement to Medical Mutual and the Plan to do this
- To inform you of other health-related benefits or services that may be of interest to you

Uses and Disclosures with Your Permission: Medical Mutual and the Plan will not use or disclose your information for any purpose not outlined in this notice unless you give Medical Mutual and the Plan your written authorization to do so. We do not make disclosures of information to any other companies that may want to sell their products or services to you. If you give Medical Mutual and the Plan your written authorization, you may revoke that authorization at any time unless Medical Mutual and the Plan has taken action in reliance of your authorization. To receive an authorization form, please contact Customer Service or print one from our Web site, www.MedMutual.com, under the Members' section. If a family member calls with knowledge of your claim, we may confirm certain information about it, unless you have informed us in writing of a need for confidential communication.

Your Rights

Below are your privacy and confidentiality rights as a member of Medical Mutual and the Plan. Please note that all requests must be made in writing either by a personal letter or by filling out the appropriate Privacy & Confidentiality Request Form that can be found in the Members' section of www.MedMutual.com. You also may call Customer Service to obtain a copy of this form. All completed forms and requests are to be mailed to:

Medical Mutual
P.O. Box 89499
Cleveland, OH 44101-6499

Requests with incomplete information will not be processed, and you will not be notified.

Restriction: You may request that Medical Mutual and the Plan place additional restrictions on the use and disclosure of your information to carry out treatment, payment or healthcare operations. Medical Mutual and the Plan does not have to agree to your request. Your request must be made in writing and include your name, your birthday, the policy number under which you are covered and a clear explanation of your request. Medical Mutual and the Plan will send a written confirmation regarding the disposition of your request.

Confidential Communication: You may request that Medical Mutual and the Plan communicate with you in confidence about your information at a different location. Medical Mutual and the Plan do not have to honor this request unless: (1) such a change in communication is necessary to avoid endangering you; (2) your request allows Medical Mutual and the Plan to continue collecting premiums and pay claims; and (3) your request is reasonable. Your request must be made in writing and contain your name, your Social Security number, your birthday, the policy number under which you are covered, the full address where you would like future communications to be sent and the reason for the request.

The request will take 10 business days to process from the date received. You will receive a letter confirming the activation of the alternate address. All communications regarding your information will be sent to the alternate address once this request has been made or until you notify us otherwise. Use of an alternate address cannot be applied to communications sent prior to processing your request.

Access to Your Information: You have a right to access your information used and stored by Medical Mutual in its designated record set. For access to your entire medical record, you will have to contact the provider of service. All requests for access must be made in writing and include your name, your birthday, the policy number under which you are covered, the group number under which you are covered, your Social Security number, the information you would like to access and the dates of the information you would like to see (if applicable).

Amend Your Information: You have the right to request an amendment of your information. Medical Mutual and the Plan cannot amend information it did not create and will refer you to the provider of service if you are requesting an amendment to diagnosis or treatment information. All requests must be made in writing and include your name, your birthday, the policy number under which you are covered, the information you are requesting be amended and an explanation as to why you believe the information is incorrect or incomplete. You have a right to an appeal if your request to an amendment is denied. These rights will be explained to you if your request is denied.

Disclosures: You have the right to an accounting of certain disclosures of your information made by Medical Mutual and the Plan and business associates over the last six (6) years (but not for disclosures made before April 14, 2003). All requests must be made in writing and include your name, your birthday, the policy number under which you are covered and a statement explaining your specific request. Complaints: You have the right to complain if you believe your rights have been violated. All complaints will need to include the following information: your name, your birthday, the policy number under which you are covered and an explanation regarding your complaint in as much detail as possible. You may file a complaint by contacting Customer Service if you do not wish to send it in writing.

You also have the right to complain to the Secretary of the U.S. Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C., 20201. Federal law prohibits retaliation against you if you choose to file a complaint.

Contact Information: If you have questions or would like an additional copy of this notice, please contact Customer Service.

The effective date of this notice was April 14, 2003. Medical Mutual and the Plan are required to follow the terms of this notice until it is replaced. Medical Mutual and the Plan reserve the right to change this Privacy Notice at any time as allowed by law and will notify you of any changes as required by law. Medical Mutual reserves the right to make the changes that apply to all information that it maintains.

Legal Actions

No action, at law or in equity, shall be brought against Medical Mutual or the Plan to recover benefits until you have properly filed a claim and exhausted your internal and external appeals rights. It is very important that you follow these claims and appeals procedures as described in this Benefit Book. 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

Coordination of Benefits is the procedure used to pay health care expenses when you or an Eligible Dependent is covered by more than one health care plan. The Plan follows rules established by Ohio law to decide which health care plan pays first and how much the other health care plan must pay. The objective is to make sure the combined payments of all health care plans are no more than your actual bills.

When you or your Eligible Dependents are covered by another group health care plan in addition to this one, the Plan will follow Ohio coordination of benefit rules to determine which health care plan is primary and which is secondary. You must submit all bills first to the primary health care plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary health care plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary health care plan.

The Plan pays for health care only when you follow the Plan's rules and procedures. If the Plan's rules conflict with those of another health care plan, it may be impossible to receive benefits from both health care plans, and you will be forced to choose which health care plan to use.

Plans That Do Not Coordinate Benefits

The Plan will pay benefits without regard to benefits paid by the following kinds of coverage:

- medicaid;
- Group hospital indemnity coverages which pay less than \$100 per day;
- school accident coverage; and
- some supplemental sickness and accident policies.

How the Plan Pays As Primary

When this Plan is primary, it will pay the full benefit provided by your Benefit Book as if you had no other coverage.

How the Plan Pays As Secondary

- When this Plan is secondary, its payments will be based on the balance left after the primary health care plan has paid. The Plan will pay no more than that balance. In no event will the Plan pay more than it would have paid had this Plan been primary.
- The Plan will pay only for health care services that are covered under this Benefit Book.
- The Plan will pay only if you have followed all of the Plan's procedural requirements, including precertification.
- The Plan will pay no more than the "allowable expense" for the health care involved.

Which Health Care Plan is Primary?

To decide which health care plan is primary, the Plan has to consider both the coordination of benefits provisions of the other health care plan and which member of your family is involved in a claim. The primary health care plan will be determined by the first of the following which applies:

- **Non-coordinating Plan** - If you have another Group plan which does not coordinate benefits, it will always be primary.
- **Employee** - The plan which covers you as an employee (neither laid off nor retired) is always primary.
- **Children (Parents Divorced or Separated)** - If the court decree makes one parent responsible for health care expenses, that parent's plan is primary.

If the court decree gives joint custody and does not mention health care, the Plan follows the birthday rule as discussed below.

- **Children and the Birthday Rule** - When your children's health care expenses are involved, the Plan follows the "birthday rule". The health care plan of the parent with the first birthday in a calendar year is always primary for the children. For example: If your birthday is in January and your spouse's birthday is in March, your health care plan will be primary for all of your children.

However, if your spouse's health care plan has some other coordination of benefits rule (for example, a "gender rule" which says the father's health care plan is always primary), the Plan will follow the rules of that health care plan.

Coordination Disputes

If you believe that the Plan has not paid a Coordination of Benefits claim properly, you should attempt to resolve the problem by contacting Medical Mutual or BGSU.

Provision Enforcement

The Plan will coordinate benefits to the extent that the Plan is informed by you or some other person or organization of your coverage under any other health care plan. The Plan is not required to determine if and to what extent you are covered under any other health care plan.

In order to apply and enforce this provision or any provision of similar purpose of any other health care plan, it is agreed that:

- any person claiming benefits described in this Benefit Book will furnish the Plan and/or Medical Mutual with any information the Plan or Medical Mutual needs; and
- the Plan and Medical Mutual may, without the consent of or notice to any person, release to or obtain from any source any necessary information.

Facility of Payment

If payment is made under any other health care plan which the Plan should have made under this provision, then the Plan has the right to pay whoever paid under the other health care plan; the Plan will determine the necessary amount under this provision. Amounts so paid are benefits under this Benefit Book and the Plan is discharged from liability to the extent of such amounts paid for Covered Services.

Right of Recovery

If the Plan pays more for Covered Services than this provision requires, Medical Mutual has the right to recover on behalf of the Plan, the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure the Plan's right to recover the excess payment.

Right of Subrogation and Reimbursement

Subrogation

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

Reimbursement

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

Your Duties

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

Changes In Benefits or Provisions

The benefits provided by this coverage may be changed at any time. It is BGSU's responsibility to notify you when these changes go into effect. If you are receiving Covered Services under this Benefit Book at the time your revised benefits become effective, the Plan will continue to provide benefits for these services only if they continue to be Covered Services under the revised benefits.

Termination of Coverage

How and When Your Coverage Stops

Your coverage stops:

- By termination of the Contract with Medical Mutual including termination for non-payment. This automatically ends all of your coverage. It is the responsibility of BGSU to notify you of such termination.
- On the date that a Covered Person stops being an Eligible Dependent.
- At the end of the month in which the Card Holder becomes ineligible, when a Covered Person stops being an eligible Card Holder.
- At the end of the period for which payment was made when a Covered Person does not pay the required contribution.
- On the last day of the month in which 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, (except as required by continuation of coverage rules).
- 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 information provided to the Plan or Medical Mutual or commits fraud or forgery.

Creditable Coverage

The Plan will provide a certification of creditable coverage should the Card Holder or Eligible Dependent terminate coverage under this Plan and would need the information to qualify for a waiver of preexisting conditions under what group health care plan he/she is joining.

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

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

- an individual must have an 18 month period of Creditable Coverage, with final coverage through a group health plan, including church and governmental plans; health insurance coverage; Part A or Part B of Title XVIII of the Social Security Act (Medicare); the health plan for active military personnel, including CHAMPUS; the Indian Health Service or other tribal organization program; a state health benefits risk pool; the Federal Employees Health Benefits Program; a public health plan as defined in federal regulations; a health benefit plan under section 5 (c) of the Peace Corps Act; or any other plan which provides comprehensive hospital, medical and surgical services. Coverage after which there was a break of 63 or more days does not count in the period of Creditable Coverage. Creditable Coverage will be counted based on the standard method, without regard to specific benefits.
- an individual must apply within 62 days of the end of the final coverage;
- an individual must not be eligible for coverage under a group health plan, Medicare or Medicaid;
- an individual must not have other health insurance coverage;
- an individual whose most recent prior coverage has not been terminated for nonpayment of premium or fraud; and

- if the individual elected COBRA coverage or Ohio extension of coverage, the individual must exhaust all such continuation coverage to become a Federally Eligible Individual. Termination for nonpayment of premium does not constitute exhausting such coverage.

A Card Holder, who is a reservist, called or ordered to active duty or the spouse or an Eligible Dependent of such reservist has special rights under federal law to continue coverage. Coverage may continue for a period of eighteen months after the date on which the coverage would otherwise terminate. The eighteen month continuation of coverage can be extended to a thirty-six month period if any of the following occurs during the eighteen month period:

- the death of a reservist;
- the divorce or separation of a reservist from the reservist's spouse;
- the cessation of dependency of a child pursuant to the terms of the Benefit Book.

To elect such continued coverage, reservists eligible for continuation of coverage have thirty-one days from the date coverage would otherwise end to file a written request and pay the first contribution to the employer.

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

Benefits After Termination of Coverage

If you are an Inpatient of a Hospital or Skilled Nursing Facility on the day your coverage stops, only the benefits listed in the **Inpatient Hospital Services** section under **bed, board and general nursing services** and **ancillary services** will continue. These benefits will end when any of the following occurs:

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

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

DEFINITIONS

Alcoholism - a Condition classified as a mental disorder and described in the International Classification of Diseases, ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as alcohol dependence, abuse or alcoholic psychosis.

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

Benefit Book - this document.

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

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

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

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

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

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

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

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

Contracting - the status of a Hospital or Other Facility Provider:

- which has an agreement with Medical Mutual or Medical Mutual's parent company about payment for Covered Services; or
- which is designated by Medical Mutual or its parent as Contracting.

Copayment - a dollar amount, as specified in the Schedule of Benefits that you are required to pay at the time Covered Services are rendered.

Covered Charges - the Billed Charges for Covered Services, except that Medical Mutual reserves the right to limit the amount of Covered Charges for non-Emergency Covered Services provided by a Non-Contracting Institutional Provider.

Covered Person - the Card Holder, and if family coverage is in force, the Card Holder's Eligible Dependent(s).

Covered Service - a Provider's service or supply as described in the Health Care Benefits section of this Benefit Book for which the Plan will provide benefits, as listed in the Schedule of Benefits.

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

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

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

Custodial Care - care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting their activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes but is not limited to:

- administration of medication which can be self-administered or administered by a lay person; or
- help in walking, bathing, dressing, feeding or the preparation of special diets.

Custodial Care does not include care provided for its therapeutic value in the treatment of a Condition.

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

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

Drug Abuse - a Condition classified as a mental disorder and described in the International Classification of Diseases, ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as drug dependence abuse or drug psychosis.

Effective Date - 12:01 a.m. on the first of the month following the employee's date of hire.

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

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

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

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

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

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

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

Incurred - rendered to you by a Provider. All services rendered by the Institutional Provider during an Inpatient admission are considered to be Incurred on the date of admission.

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

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

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

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

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

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

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

Medical Emergencies include heart attacks, strokes, loss of consciousness or respiration, convulsions and other severe Conditions which the Plan determines to be Medical Emergencies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Alcoholism Treatment Facility** - a facility which mainly provides detoxification and/or rehabilitation treatment for Alcoholism.
- **Ambulatory Surgical Facility** - a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a Physician and also includes nursing services.
- **Day/Night Psychiatric Facility** - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the Outpatient treatment of Mental Illness. These services are provided through either a day or night treatment program.
- **Dialysis Facility** - a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- **Drug Abuse Treatment Facility** - a facility which mainly provides detoxification and/or rehabilitation treatment for Drug Abuse.
- **Home Health Care Agency** - a facility which meets the specifications of Chapter 3701.88 of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio and which provides nursing and other services as specified in the Home Health Care Services section of this Benefit Book. A Home Health Care Agency is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Hospice Facility** - a facility which provides supportive care for terminally ill patients as specified in the Hospice Services section of this Benefit Book.
- **Psychiatric Facility** - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.
- **Psychiatric Hospital** - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Inpatient basis. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must be provided under the supervision of a registered nurse.
- **Skilled Nursing Facility** - a facility which primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a Physician.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Surgery -

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

Traditional Amount - the maximum amount determined and allowed by Medical Mutual for a Covered Service based on factors, including the following:

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

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

- has consistent, fair and practical criteria for selecting patients for transplants;
- has a written agreement with an organization that is legally authorized to obtain donor organs; and
- complies with all federal and state laws and regulations that apply to transplants covered under this Benefit Book.

United States - all the states, the District of Columbia, the Virgin Islands, Puerto Rico, American Samoa, Guam and the Northern Mariana Islands.

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