COUNCIL OF SMALLER ENTERPRISES

CAVALIERS HOLDINGS LLC

Group Number
334363-109

Dental PPO Network Certificate

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

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MEDICAL MUTUAL®

For Use With Non-Grandfathered Group PPO, POS and Indemnity Plans

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

AMENDMENT

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

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

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

The following Definition is added to your Plan:

"Essential Health Benefits" is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Your Plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your Plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this Amendment.

Emergency Services

"Stabilize" means, to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department.

For PPO and POS Plans only: Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from an out of network provider. However, an out of network provider of Emergency Services that does not have a contract with Medical Mutual may send you a bill for any charges remaining after your Plan has paid (this is called "balance billing").

Except where your Plan provides a better benefit, your Plan will apply the same copayments and coinsurance for out of network Emergency Services as it generally requires for in network Emergency Services. A deductible may be imposed for out of network Emergency Services, only as part of the deductible that generally applies to out of network benefits. Similarly, any out-of-pocket maximum that generally applies to out of network benefits will apply to out of network Emergency Services.

Your Plan will calculate the amount to be paid for out of network Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount your Plan pays to in network providers

for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with in-network providers for the services furnished); 2) the amount that would be paid using the same method your Plan generally uses to determine payment for out of network services (the Non-Contracting Amount) but substituting in network copayments and coinsurance amounts; and (3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any in network copayments or coinsurance.

Lifetime Dollar Limits

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

Annual Dollar Limits

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

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

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

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

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

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

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

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

Rescission of Coverage

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

Preventive Health Benefits

Under Ohio law, the following preventive health benefits are required to be provided in your Plan:

- Initial Mammography starting at age 35
- Annual screening for cervical cancer
- Child Health Supervision

Your Plan provides additional coverage for selected preventive services, as shown below. These preventive services will be covered without a copayment, coinsurance or deductible. However, for PPO and POS Plans, no copayment, coinsurance or deductible will apply when these services are delivered by a network provider. Depending upon your age, services may include:

- Screenings and tests for diseases
- Mental Health screenings, including substance abuse
- Healthy lifestyle counseling
- Vaccines and immunizations
- Pregnancy counseling and screenings
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Please contact us at MedMutual.com or at the phone number shown on your ID card, if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/prevention/index.html.

Dependent Coverage (for Plans that make dependent coverage available)

Federal law

This Plan will cover your married or unmarried child as defined in the Eligibility section of this Plan until your child reaches age 26.

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

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

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

- not married;
- the natural child, stepchild or adopted child of the Certificate Holder or the Certificate Holder's spouse;
- a resident of Ohio;
- if not an Ohio resident, a Full-time Student at an accredited public or private institution of higher education;

- not employed by an employer that offers any health benefit Plan under which the child is eligible for coverage; and
- not eligible for coverage under Medicaid or Medicare.

Internal Claims and Appeals and External Review Process:

1. The following is added to the list of information included in all notices of a denial of a benefit determination:
   a. Sufficient information to identify the claim, including the date of services, the health care provider, and the claim amount, if applicable.
   b. In the case of a final internal benefit determination, a discussion as to how the decision was made.
2. The provision for Filing an Appeal is amended as follows:
   a. Under the Expedited Review Process:
      1. Expedited reviews will be resolved within 72 hours after you have submitted the request.
      2. When you request an internal appeal for an urgent care claim or for a concurrent care claim that is urgent, you may also file a request at the same time for an external appeal.
   b. You may also file an appeal for the following:
      1. A determination of your eligibility to participate in the plan or health insurance coverage.
      2. A decision to rescind your coverage. (A rescission does not include a retroactive cancellation for failure to timely pay required premiums.)
   c. You will receive continued coverage pending the outcome of the appeals process. This means that Medical Mutual may not reduce or eliminate coverage of ongoing treatment until your appeal is exhausted.
3. The provision for First Level Mandatory Appeal for Medical Necessity Denial is amended as follows:
   a. Health care professionals who review the appeal act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits.
   b. You may submit written comments, documents, records, as well as testimony and other information relating to the claim being appealed.
   c. If, during the appeal, Medical Mutual considers, relies upon or generates any additional evidence, you will be provided free of charge with copies of that evidence. You will have an opportunity to respond before our time frame for making a decision has expired.
   d. All notices of a denial of benefits will include sufficient information to identify the claim, including the date of services, the health care provider and the claim amount, if applicable.
   e. If Medical Mutual has not substantially complied with the internal claims appeals process, you may choose to initiate the external appeal process.
4. The provision for External Review for Urgent Care Claim Appeals is amended as follows:
   a. You may also request an external review for Urgent or Expedited claims at the same time you request an internal review of your claims.
   b. The review panel will issue a written decision within seventy-two hours after you have submitted the request.

No Preexisting Condition Limitations for Covered Persons under age 19

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

For Point-of-service Plans:

Direct Access to Obstetricians and Gynecologists: For Point-of-service Plans

You do not need prior authorization from us or any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment Plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Medical Mutual at the phone number shown on your ID card or at MedMutual.com.

Selection of a Primary Care Provider

We generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

Until you make this designation, Medical Mutual designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Medical Mutual at the phone number shown on your ID card or at MedMutual.com.

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

IN WITNESS WHEREOF:

Medical Mutual of Ohio

Steven C. Glass
President and CEO

DENTAL PPO NETWORK SCHEDULE OF BENEFITS

Benefit Period	Calendar year
Benefit Period Deductible	$50 single
Maximum Benefit Payable per Covered Person per Benefit Period	$1,500
Dependent Age Limit	The end of the month of the 26th birthday, if he or she meets the requirements of an Eligible Dependent. See "Eligibility" for optional extension to age 28.

IMPORTANT - Read This Section

The choice of a Provider is solely yours. Dental Providers are designated as PPO Network or Non-PPO Network.

The amount of benefits which you will receive for Covered Services may vary depending upon the status of the Provider. To receive maximum benefits, Covered Services must be provided by PPO Network Providers. When Covered Services are provided by Non-PPO Network Providers, your benefits may be lower. This Schedule of Benefits tells you how much Medical Mutual will provide for benefits for Covered Services provided by PPO Network Providers and Non-PPO Network Providers.

You will receive a list of PPO Network Providers. The status of a Provider may change from time to time. You should be sure of the status of your Provider before receiving Covered Services.

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

Type of Service	**Maximums and Limitations**
Initial and Periodic Oral Evaluations	Two evaluations per Benefit Period
Bitewing x-rays	Two sets per Benefit Period
Full mouth/Panoramic x-rays	One within a 36 month period
Prophylaxis	Two per Benefit Period
Topical Fluoride Applications	Two per Benefit Period for Eligible Dependent children under age 14
Dental Sealants[1]	One within a 36 month period for Eligible Dependent children under age 16
Space Maintainers	For Eligible Dependent children under age 16
Inlays	Once every five years per tooth
Onlays	Once every five years per tooth
Crowns	Once every five years per tooth
Fixed Partial Dentures (Bridges)	Once every five years per unit
Dentures (Complete and Partial)	Once every five years Relining and rebasing is covered if done no less than six months after initial placement but not more than once in any 36 month period. One replacement of a temporary denture if a permanent denture is installed within 12 months of the installment of the temporary denture.

[1] Dental sealants are limited to eligible teeth free from decay or restorations on the occlusal surface.

DENTAL PAYMENT SCHEDULE		
Type of Service	**PROVIDER OF SERVICES**	
	PPO Network Provider	**Non-PPO Network Provider**
	YOU PAY THE FOLLOWING	
Routine Preventive Services • initial and periodic oral evaluations • bitewing x-rays • full mouth/panoramic x-rays • diagnostic x-rays • prophylaxis • space maintainers • topical fluoride applications • emergency palliative treatments • dental sealants[1]	0% of Lesser Amount No Deductible is required for these services.	0% of Lesser Amount No Deductible is required for these services.
Essential Services • consultations/other evaluations • fillings • endodontic services • periodontal services • extractions • impactions • repairs, relines & adjustments of prosthetics • general anesthesia • IV sedation • minor oral surgery	0% of Lesser Amount	20% of Lesser Amount
Oral Surgery - Harvest of Bone for Autogenous grafting procedure	20% of Lesser Amount	40% of Lesser Amount
Complex Services • inlays • onlays • crowns • fixed partial dentures (bridges) • dentures (complete & partial)	40% of Lesser Amount	50% of Lesser Amount
Orthodontic Services	50% of Lesser Amount	50% of Lesser Amount

ORTHODONTIC SERVICES	
Maximum Benefit Payable per Covered Person	$1,500 per lifetime
Eligibility	Available for all Covered Persons, regardless of age.
Deductible	No Deductible is required for Orthodontic services.

BENEFIT VERIFICATION

Required for any Course of Treatment exceeding $200 or involving major restorations.

DENTAL PPO NETWORK CERTIFICATE

This Certificate describes the dental benefits available to you as part of a Contract between an association of smaller enterprises and Medical Mutual of Ohio (Medical Mutual). It is subject to the terms and conditions of the Contract. This is not a summary plan description or an Employee Retirement Income Security Act (ERISA) Plan Document by itself. However, it may be attached to a document prepared by your Group that is called a summary plan description. The employer or organization which pays or forwards the fees will be referred to as the Group.

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

- apply for coverage under the Group Contract;
- pay for coverage if necessary;
- satisfy the conditions specified in the Eligibility section; and
- be approved by Medical Mutual.

Medical Mutual shall have the right to interpret and apply the terms of this Certificate. The decision about whether to pay any claim, in whole or in part, is within the discretion of Medical Mutual, subject to any available appeal process.

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

Medical Mutual of Ohio (Medical Mutual)

HOW TO USE YOUR CERTIFICATE

This Certificate describes your dental benefits. Please read it carefully.

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

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

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

The **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 Dental Benefits section.

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

DEFINITIONS

Active Treatment - the treatment of adjusting an Orthodontic appliance to apply effective force to the teeth or jaws.

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

Benefit Period - the period of time specified in the Schedule of Benefits during which Covered Services are rendered and benefit maximums 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.

Benefit Verification - the method by which Medical Mutual determines Covered Services and benefits that will be provided for a proposed service or Course of Treatment. For further information see the How Claims are Paid section.

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

Certificate - this document.

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

Clinically Necessary (Clinical Necessity) - a service or supply that is required to diagnose or treat a Condition and which Medical Mutual determines is:

- appropriate with regard to the standards of good dental practice;
- not primarily for your convenience or the convenience of a Dental Provider; and
- the most appropriate supply or level of service which can be safely provided to you.

Coinsurance - a percentage of the Fee Schedule Amount for Covered Services for which you are responsible after you have met your Deductible.

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

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

Course of Treatment - a planned series of procedures or treatments performed by a Dental Provider.

Covered Charges - the Billed Charges for Covered Services.

Covered Person - the Certificate Holder, and if family coverage is in force, the Certificate Holder's Eligible Dependent(s), as defined in the Eligibility section of this Certificate.

Covered Service - a Dental Provider's service or supply as described in the Dental Benefits section of this Certificate for which Medical Mutual will provide benefits, as listed in the Schedule of Benefits.

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.

Dental Provider - a Dentist or Physician who provides Covered Services as described in the Dental Benefits section of this document.

Dental Specialist - an oral surgeon, endodontist, periodontist, prosthodontist or orthodontist.

Dentist - a licensed professional who treats diseases and injuries to the teeth and oral cavity.

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

Emergency Palliative Treatment - treatment given in response to a painful or dangerous situation to relieve pain and remove a person from immediate danger without rendering definitive treatment (such as a filling).

Excess Charges - the amount of Billed Charges less Non-Covered Charges in excess of the Fee Schedule Amount for a Non-PPO Network Provider.

Experimental or Investigational Drug, Device, Dental Treatment or Procedure - a drug, device, dental 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, dental 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, dental 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 dental 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, dental treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, dental treatment or procedure. Determination will be made by Medical Mutual at its sole discretion and will be final and conclusive, subject to any available appeal process.

Fee Schedule Amount - the maximum dollar allowance for Covered Services that PPO Network Providers have agreed to accept as payment in full. Non-PPO Network Providers will also be reimbursed based on the Fee Schedule Amount.

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

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

Incurred - rendered to you by a Dental 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 PPO Network Providers, the Lesser Amount means the Lesser of the Negotiated Amount or the Covered Charges. For Non-PPO Network Providers, the Lesser Amount means the Fee Schedule Amount.

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

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

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

The Negotiated Amount for 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-Covered Charges - Billed Charges for services and supplies that are not Covered Services.

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

Non-PPO Network Provider - a Dentist or Physician which is not designated by Medical Mutual as a PPO Network Provider.

Orthodontics - the specialty and practice of preventing and correcting irregularities of the teeth, as by braces.

Periodontal Services - procedures including examination, diagnosis and treatment (including Surgery) of disease affecting the surrounding and supporting tissues of the teeth.

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

PPO Network Provider - a Dentist or Physician designated by Medical Mutual as a PPO Network Provider.

Retention Treatment - the period of Orthodontic treatment during which the individual is wearing an appliance to maintain the teeth in position.

Rider - a document that amends or supplements your coverage.

Surgery -

- the performance of generally accepted operative and other invasive procedures of the teeth, bone and soft tissue of the oral structures;
- referring specifically to the operative/cutting procedure of the teeth, bone and soft tissue of the oral structures which are considered within the scope or practice by the provider's license and specialty and/or as determined by the State Dental Board;
- utilized to correct pathology as a result of decay, fracture, damage, loss and infection that would necessitate tissue removal, prosthesis placement, placement of dental materials and medicaments and/or tissue architecture modifications;
- usual and related preoperative and postoperative care; or
- other procedures as reasonably approved by Medical Mutual.

ELIGIBILITY

Applying for Coverage

Prior to receiving this Certificate, you applied for individual coverage or family coverage. For either coverage, you completed an Application. There may be occasions when the information on the Application is not enough. Medical Mutual will then request the additional data needed to determine whether or not to approve the enrollment. Coverage will not begin until your enrollment has been approved and you have been given an Effective Date.

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

Eligible Dependents

An Eligible Dependent is:

- the Certificate Holder's spouse;
- the Certificate Holder's Domestic Partner;

  To be considered an eligible Domestic Partner, the Certificate Holder and the Domestic Partner:

  - must be of the same sex
  - must cohabit and reside together in the same residence, reside together in the same residence for at least six months and intend to do so indefinitely;
  - must be engaged in an exclusive and committed relationship and be financially interdependent;
  - both must be at least 18 years of age and be each other's sole Domestic Partner;
  - must not be married or separated from anyone else;
  - must not have had another domestic partner within six months of establishing the current domestic partnership;
  - must not be related by blood; and
  - must not be in this relationship solely for the purpose of obtaining benefits coverage.
  - The Certificate Holder must provide a Domestic Partner Declaration and a medical history form, with supporting documentation, to Medical Mutual prior to enrolling the dependent Domestic Partner.
- the Certificate Holder's, spouse's or Domestic Partner's:
  - natural children;
  - stepchildren;
  - legally adopted children;
  - children for whom either the Certificate Holder, Certificate Holder's spouse or Domestic Partner is the Legal Guardian or Custodian; or
  - any children who, by court order, must be provided health care coverage by the Certificate Holder or Certificate Holder's spouse or Domestic Partner.

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

Optional Extension

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

- not married;
- a resident of Ohio;
- if not an Ohio resident, a Full-time Student at an accredited public or private institution of higher education;

- not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and
- not eligible for coverage under Medicaid or Medicare.

Eligibility will continue past the age limit for Eligible Dependents who are unmarried and primarily dependent upon the Certificate 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 Medical Mutual 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, Medical Mutual may annually require further proof that the dependence and incapacity continue.

Effective Date

Coverage starts at 12:01 a.m. on the Effective Date. The Effective Date is determined by your Group and Medical Mutual. No benefits will be provided for services, supplies or charges Incurred before your Effective Date.

Changes in Coverage

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

A spouse and other dependents who becomes eligible by reason of marriage will be effective on the date of the marriage if an Application for their coverage is submitted to Medical Mutual within 31 days of the marriage. A Domestic Partner who becomes eligible by reason of entering into a Domestic Partnership may be added if application is made during an open enrollment period. A newborn child or an adopted child will be covered for 31 days from birth or adoptive placement in the home. If payment of a specific premium is required to provide coverage for an additional child, that is, if you are changing from individual to family coverage, you must submit an Application to Medical Mutual within 31 days of birth in order to continue coverage beyond 31 days for the additional child. Coverage will continue for the adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

If a premium change (as described above) is required and Medical Mutual is not notified of the change within 31 days of the event, the Effective Date of your coverage will be determined in accordance with the Group Contract. It is important to complete and submit your Application promptly as the date this new coverage begins will depend on when you apply.

Under Ohio law, certain changes in circumstance (i.e., moving back to Ohio) provide for an additional enrollment opportunity for dependent children. Contact your Group benefits administrator for additional information.

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

Your Identification Card

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

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

DENTAL BENEFITS

This section describes the services and supplies covered if provided and billed by a Dental Provider. When alternate methods of treatment are available, the allowable amount will be based on the least costly method of treatment that Medical Mutual deems appropriate and Clinically Necessary. All Covered Services must be medically or Clinically Necessary.

The following are Covered Services:

- initial and periodic oral evaluations
- bitewing x-rays
- prophylaxis (cleaning)
- topical fluoride applications
- dental sealants, limited to eligible teeth free from decay or restorations on the occlusal surface
- space maintainers
- Emergency Palliative Treatment, including emergency oral evaluations
- diagnostic x-rays
- full-mouth/panoramic x-rays
- consultations and other evaluations by a Dental Specialist
- minor restorative services, including, but not limited to, fillings
- endodontic procedures, including pulpotomy, root canal treatment and apicoectomy (removal of the apex of the tooth root)
- Periodontal services, including removal of gum tissue around the necks of the teeth and the recontouring of the gum tissue
- repairs, relines and adjustments of prosthetics (complete and partial dentures, crowns, fixed partial dentures (bridges))
- extractions, including simple and surgical extractions and impactions
- minor oral Surgery, including alveoloplasty (Surgery performed on the alveolar bone, including flap entry and closure) and vestibuloplasty
- general anesthesia for a covered oral or dental Surgery
- inlays
- onlays
- crowns that are not part of a fixed partial denture, including stainless steel crowns
- prosthetics, including complete dentures, fixed partial dentures (bridges), and removable partial dentures, are subject to the following:
    - If an appliance can be made serviceable, a replacement appliance is not covered. Refer to the Schedule of Benefits for more details.
    - Coverage is limited to standard procedures. Personalized restorations and specialized techniques in constructing dentures or fixed partial dentures are not covered.
- Orthodontic services consisting of installing tooth straightening appliances and all treatments for abnormally positioned teeth, are subject to the following limitations:
    - Benefits for Orthodontic services will be provided only as services are Incurred.
    - When you are already receiving Active or Retention Treatment on your Effective Date, only services Incurred after your Effective Date will be covered based on a proration of the expected months of treatment.

EXCLUSIONS

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

1. Not prescribed by or performed by or under the direction of a Dental Provider.
2. Not performed within the scope of the Dental Provider's license.
3. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual.
4. For a Condition that occurs as a result of any act of war, declared or undeclared.
5. For which you have no legal obligation to pay in the absence of this or like coverage.
6. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
7. Incurred or received after you stop being a Covered Person.
8. Received from a member of your Immediate Family.
9. For a Condition occurring in the course of employment or for occupational injuries sustained by sole proprietors, if whole or partial benefits or compensation could be available under the laws of any governmental unit. This applies whether or not you claim such compensation or recover losses from a third party.
10. For charges in excess of the amount Medical Mutual determines to be allowable.
11. Rendered by more than one Dental Provider. If you change Dental Providers during a Course of Treatment or if more than one Dental Provider treats you for a procedure, additional benefits are not provided.
12. For appliances or restorations needed to increase or restore the vertical dimension or to restore and/or correct the occlusion.
13. For congenital or developmental malformation or other services primarily to improve appearance.
14. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
15. For the repair of a damaged space maintainer or replacement of a lost or stolen space maintainer.
16. For Outpatient educational, vocational or training purposes except as may be specified.
17. Received in a military facility for a military service related Condition.
18. For which payment was made or would have been made under Medicare Part B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
19. For Experimental or Investigational Drugs, Devices, Dental Treatments or Procedures.
20. For fraudulent or misrepresented claims.
21. For dental implants.
22. For personalized restorations, specialized techniques in constructing dentures or partial fixed dentures or replacement of appliances that can be made serviceable.
23. For instruction for plaque control, oral hygiene and diet.
24. For non-covered services or services specifically excluded in the text of this Certificate.

GENERAL PROVISIONS

How to Apply for Benefits

Notice of Claim; Claim Forms

A claim must be filed for you to receive benefits. All PPO Network Providers and many Non-PPO Network Providers will submit a claim for you; if you submit it yourself, you should use a claim form. In most cases, you can obtain a claim form from your Group or Dental Provider. If your Dental 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/member.

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 dental 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 a Dental 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 unless written or electronically submitted proof that Covered Services have been given to you is received. Proof must be given within 90 days of your receiving Covered Services or as soon as is reasonably possible. No proof can be submitted later than one year after services have been received.

If you fail to follow the proper procedures for filing a Claim as described in this Certificate, you or your authorized representative, as appropriate, shall be notified of the failure and the proper procedures as soon as possible, but not later than five (5) days following the original receipt of the request. We may notify you orally unless you provide us with a written request to be notified in writing. Notification under this section is only required if both (1) the claim communication is received by the person or department customarily responsible for handling benefit matters and (2) the claim communication names a specific claimant, a specific medical condition and a specific treatment, service or product for which approval is requested.

How Claims are Paid

Benefit Period Deductible

Each Benefit Period, you must pay the dollar amount that may be specified in the Schedule of Benefits as the Deductible before Medical Mutual will begin to provide benefits. This is the amount of expense that must be Incurred and paid by you for Covered Services before Medical Mutual starts to provide benefits. If a benefit is subject to a Deductible, only expenses for Covered Services under that benefit will satisfy the Deductible. To satisfy your Deductible, Medical Mutual 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.

The Schedule of Benefits specifies a single Deductible. The single Deductible is the amount each Covered Person must pay.

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 your Schedule of Benefits. The amount of Coinsurance you have to pay may vary depending on the status of your Dental Provider.

Schedule of Benefits

The Deductible that may apply will renew each Benefit Period. Some of the benefits offered in this Certificate have maximums. In addition, there may be a lifetime maximum for all Covered Services listed in this Certificate.

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 and Billed Charges for all services and supplies after benefit maximums have been reached. You may also be responsible for Excess Charges if your Dental Provider does not accept the Fee Schedule Amount as payment in full. Your financial responsibilities include the Deductible amounts specified in the Schedule of Benefits. Coinsurance is also your responsibility. PPO Network Providers have agreed to accept the Fee Schedule Amount as payment in full. In cases where there are alternate methods of treatment with different fees, and you select the more expensive treatment or service, you are responsible for all charges in excess of the allowable amount deemed appropriate and Clinically Necessary by Medical Mutual, even if a PPO Network Provider is used.

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

Direction of Payment

The choice of a Dental Provider is yours. After a Dental Provider performs a Covered Service, Medical Mutual will not honor your request to withhold claim payment. Medical Mutual does not furnish Covered Services but only pays for Covered Services you receive from Dental Providers. Medical Mutual is not liable for any act or omission of any Dental Provider. Medical Mutual has no responsibility for a Dental Provider's failure or refusal to give Covered Services to you.

Medical Mutual is authorized to make payments directly to Dental 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 Dental Provider and Medical Mutual is not 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 Dental 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, and you must repay this amount when requested.

Benefit Verification

Benefit Verification determines if proposed dental treatments:

- are consistent with the standards of good dental practice;
- are the most appropriate level of service;
- are Clinically Necessary; and
- are Covered Services.

After your Dental Provider has examined you, a proposed Course of Treatment (also known as predetermination) and the diagnostic materials, such as x-rays and study models, that support this Course of Treatment must be provided to Medical Mutual.

Your proposed Course of Treatment for Orthodontics must include the dates of all installations of appliances and all Orthodontic treatments.

Medical Mutual reserves the right to review your dental records, including diagnostic materials, to determine the most appropriate level of service. Medical Mutual may also elect to have you examined by a Dentist or Physician of its choice. Medical Mutual will then notify you and your Dental Provider which services will and will not be covered as requested, as well as the approximate amounts that will be covered. If it is determined that an alternate level of service is as appropriate as the proposed level of service, you and your Dental Provider will be notified, and benefits will be limited to the less costly service, regardless of which level of service is actually rendered (applying alternate benefits).

If you select the more costly treatment or service, you are responsible for all charges in excess of the allowable amount deemed Clinically Necessary by Medical Mutual. You are also responsible for Excess Charges if alternate benefits are applied, even if a PPO Network Provider is used. You may be responsible to pay the difference between the charges for

the higher level of service and the benefit Medical Mutual will provide for the lower level of service. If you receive services from a Non-PPO Network Provider and Medical Mutual has not obtained Benefit Verification, you may be responsible for the entire cost of the services provided.

If you use a Non-PPO Network Provider, you may be responsible and obligated to pay any and all amounts that you are charged regardless of what Medical Mutual determines to be Clinically Necessary or appropriate.

Medical Mutual evaluates cost-effective alternatives to current dental needs. In such cases, benefits not expressly covered in this Certificate may be approved. Coverage for these services must be approved in advance and in writing by Medical Mutual.

Benefit Verification does not guarantee payment. The amount payable is subject to all the Contract limitations effective at the time the services are rendered.

Explanation of Benefits

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

Time of Payment of Claims

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

Benefit Determination for Claims

Urgent Care Claims

An **Urgent Care Claim** is a claim for Dental care or treatment where applying the timeframes for non-urgent care could (a) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (b) in the opinion of a Dentist or Physician with knowledge of the claimant's medical Condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Determination of ***urgent*** can be made by (a) an individual acting on behalf of the plan and applying the judgment of a prudent lay person who possesses an average knowledge of medicine or (b) any Dentist or Physician with a knowledge of the claimant's medical Condition who can determine that a claim involves urgent care.

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

If you do not follow Medical Mutual's procedures or we do not receive all of the information necessary to make a benefit determination, Medical Mutual will notify you within 24 hours of receipt of the Urgent Care Claim of the specific deficiencies. You will have 48 hours to provide the requested information. Once Medical Mutual receives the requested information, we will notify you of the benefit determination as soon as possible but not later than 48 hours after receipt of the information.

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

Concurrent Care Claims

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

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

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

Pre-Service Claims

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

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

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

Post-Service Claims

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

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

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

Benefit Determination Notices

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

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of Medical Mutual's appeal procedures, applicable timeframes, including the expedited appeal process, if applicable;
- your right to bring a civil action under federal law following the denial of a claim after review on appeal;
- if 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 Clinical Necessity or Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your circumstances will be provided free of charge upon request.

Filing a Complaint

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, the Certificate 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 Certificate Holder with the response. If attempts to telephone the Certificate Holder are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the Certificate Holder will receive a check, Explanation of Benefits or letter explaining the revised decision.

Quality of care issues are addressed by our Quality Improvement Department or committee.

If you are not satisfied with the results, you may continue to pursue the matter through the appeal process.

Filing an Appeal

If you are not satisfied with a benefit determination decision, you may file an appeal. No more than two appeals on one claim will be conducted 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: Certificate Holder's full name; patient's full name; identification number; claim number if a claim has been denied; date of services; the Dental Provider; 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: 01-4B-4809
P.O. Box 94580
Cleveland, Ohio 44101-4580
Fax: 216/687-7990

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

First Level Mandatory Appeal

Medical Mutual offers all members a first level mandatory appeal. Under state and federal law you must complete this first level of appeal before receiving a review by the state Department of Insurance or before any action is taken in a court of law.

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.

You will be provided with notification of Medical Mutual's benefit determination of your appeal, orally as allowed or in writing, as follows:

- for an appeal of an Urgent Care Claim, not later than 72 hours after Medical Mutual receives your request for an appeal.
- for an appeal of a Pre-Service Claim, not later than 30 days after Medical Mutual receives your request for an appeal.
- for an appeal of a Post-Service Claim, not later than 30 days after Medical Mutual receives your request for an appeal.

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 Dentist or 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 Dental Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations of Clinical 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.

All notices of a denial will include the following:

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based;
- your right to bring a civil action under federal law following the denial of a claim upon review;
- 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 Clinical 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 dental 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 was denied, you have the option of a voluntary second level appeal by Medical Mutual. All requests for 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.

The second level is voluntary, which means this level of appeal is available, but not required before any civil action is pursued. Any statute of limitations will be applicable during the period of the voluntary appeal process.

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

The voluntary second level of appeal provides a full and fair review of the claim, There will be a review of your appeal by an Appeals Coordinator, a Dentist or 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 Dental Provider relating to the claim, without regard to whether such information was submitted or considered in the first level mandatory appeal. All determinations of Clinical 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.

Claim Review

Consent to Release Medical Information - Denial of Coverage

You consent to the release of medical information to when you sign an Application.

When you present your identification card for Covered Services, you are also giving your consent to release medical information to . Medical Mutual 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 Clinically Necessary and that all other conditions for coverage are satisfied. The fact that a Dental Provider may recommend or prescribe treatment does not mean that it is automatically a Covered Service.

Dental Examination

Medical Mutual may require that you have one or more dental examinations at its expense. These examinations will help to determine what benefits will be covered, especially when there are questions concerning services you have previously

received and for which you have submitted claims. These examinations will not have any effect on your status as a Covered Person or your eligibility.

Legal Actions

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

Coordination of Benefits

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

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

Definitions

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

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

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

The following are examples of expenses that are not **Allowable expenses**:

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

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

Order Of Benefit Determination Rules

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

1. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.
2. a. Except as provided in Paragraph "b" below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.
   b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
3. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
4. Each **Plan** determines its order of benefits using the first of the following rules that apply:
   a. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.
   b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order of benefits is determined as follows:
      1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
         - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
         - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

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

2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
   b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
   d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      - The **Plan** covering the **Custodial parent**;
      - The **Plan** covering the spouse of the **Custodial parent**;
      - The **Plan** covering the **non-custodial parent**; and then
      - The **Plan** covering the spouse of the **non-custodial parent**.
3. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

Effect On The Benefits Of This Plan

1. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

2. If a Covered Person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Coordination Disputes

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

Subrogation

If Medical Mutual provides benefits for Covered Services and you have the right to recover from another person, organization or insurer as a result of a negligent or wrongful act, Medical Mutual assumes your legal rights to any recovery of Incurred expenses. For the purposes of this section, "insurer" shall include, but is not limited to, (1) any insurer of any third party, (2) any insurer providing uninsured or under-insured motorist coverage, and (3) your own insurer other than Medical Mutual.

To the extent Medical Mutual provides benefits for Covered Services, you must repay Medical Mutual amounts recovered by suit, settlement or otherwise from any person, organization or insurer.

You have the legal obligation to help Medical Mutual in all possible ways when Medical Mutual tries to recover these amounts.

You must give Medical Mutual information and assistance and sign the necessary documents to help enforce Medical Mutual's rights. You must not do anything which might limit Medical Mutual's rights.

Changes In Benefits or Provisions

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

If the provisions of this Certificate are changed or revised, Medical Mutual will notify the Group 31 days prior to the changes becoming effective. It is the responsibility of the Group to notify the Certificate Holders of the change or revision.

Termination of Coverage

How and When Your Coverage Stops

Your coverage stops:

- By termination of the Group Contract including termination for non-payment. This automatically ends all of your coverage and you are not offered a conversion privilege. It is the responsibility of your Group to notify you of such termination.
- On the date that a Covered Person stops being an Eligible Dependent.
- On the date the Certificate Holder becomes ineligible, when a Covered Person stops being an eligible Certificate 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 Certificate Holder's spouse will no longer be eligible for coverage.
- On the date a Certificate Holder's Domestic Partnership ends the Domestic Partner will cease to be eligible for coverage.
- 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 Medical Mutual or commits fraud or forgery.

Continuation of Coverage

If any Covered Person's Group coverage would otherwise end, you and your Eligible Dependents may be eligible for continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You may also be eligible to continue benefits under other state or federal laws as a result of employment termination. It is your Group's responsibility to advise you of your COBRA rights and to provide you with the required documents to complete upon the qualifying event.

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

Multi-Language Interpreter Services & Nondiscrimination Notice

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

Spanish

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

Chinese

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

German

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

Arabic

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

Pennsylvania Dutch

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

Russian

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

French

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

Vietnamese

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

Navajo

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

Oromo

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

Korean

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

Italian

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

Japanese

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

Dutch

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

Ukrainian

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

Romanian

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

Tagalog

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

Order Number: Z8188-MCA R4/19
Dept of Ins. Filing Number: Z8188-MCA R9/16

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

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

Nondiscrimination Notice

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

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

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

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

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

- Electronically through the Office for Civil Rights Complaint Portal available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.