

Ohio Public Employees Retirement System

**Medical Plan Description
Medicare Secondary Plan
2019**



Message from the OPERS Health Care Division

Dear Participant:

This is the *Medical Plan Description* for your OPERS Medicare Secondary Plan. This booklet describes the coverage features of the Plan in which you and your dependents, if you have elected coverage for them, are enrolled.

It is important for you to read this booklet carefully.

Please keep these materials in your permanent records for future reference.

If you have any questions about your health care coverage, please call Medical Mutual directly at 1-877-520-6728.

Ohio Public Employees Retirement System
Health Care Division

This *Medical Plan Description* is written in plain language for the Participants who are enrolled in the OPERS Medicare Secondary Plan. It is not intended as a substitute for the federal or state law, namely the Ohio Revised Code, the Ohio Administrative Code, or the Internal Revenue Code. Rules governing the retirement system are subject to change periodically either by statute of the Ohio Legislature rules of the Ohio Public Employees Retirement Board, or the Internal Revenue Code. If you have any questions about this material, please contact OPERS or seek legal advice from your attorney.

Any Participant who, with intent to defraud or knowing that he or she is facilitating a fraud against the provider of coverage, submits an application or files a claim containing a false or deceptive statement is guilty of a crime or fraud against the legal entity providing coverage under this Plan. Such conduct may result in the termination of any or all coverage under this Plan. Any Participant who commits fraud will be responsible for any of the costs of coverage paid.

The medical plan described in this booklet is a self-insured coverage plan of the Ohio Public Employees Retirement System (OPERS); claims are paid by OPERS. This coverage is not insured with Medical Mutual of Ohio (Medical Mutual) or any of its affiliates. Medical Mutual will provide certain administrative services under the Plan. Health care coverage may change as shown in the administrative services agreement between Medical Mutual and OPERS. This Plan is not subject to ERISA.

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MEDICAL MUTUAL MEDICARE SECONDARY PLAN FEATURES

**ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS
"NOT SUBJECT TO THE DEDUCTIBLE" IS SPECIFICALLY STATED.**

OPERS Medicare Secondary Plan	
Benefit Period	Calendar Year
Deductible	\$500
Coinsurance Maximum (excludes Deductible)	\$1,000
Total Out-of-Pocket (includes Deductible and Coinsurance. Does not include Copayments.)	N/A
Maximum Out-of-Pocket (includes Deductible, Coinsurance and Copayments)	\$1,500
Lifetime Maximum	Unlimited
EMERGENCY SERVICES	
Emergency Room - Facility Charge (Emergency)	\$50* Copay 100%, not subject to the Deductible
Emergency Room Services - all other related services and Emergency Room Physician Charges (Emergency)	100%, not subject to the Deductible
Emergency Room - Facility Charge (non-Emergency)	\$50* Copay 100%, not subject to the Deductible
Emergency Room Services - Emergency Room Physician Charges (non-Emergency)	100%, not subject to the Deductible
Emergency Room Services - all other related services (non-Emergency)	80%
Urgent Care	\$50 Copay, not subject to the Deductible (Only one Copay per day is required.)
HOSPITAL, SKILLED NURSING AND HOSPICE SERVICES	
Hospital Inpatient Room and Board, including Ancillary Charges	80%
Inpatient Physician Visits and Surgical Procedures, including Anesthesiologist	80%
Pre-Admission Testing	80%
Inpatient Hospice	80%
Inpatient Mental Health Care	80%
Inpatient Substance Abuse Treatment (including Alcohol)	80%
Newborn Care - Institutional	80%
Skilled Nursing Facility (365 days per Benefit Period)	80%
MEDICAL SERVICES	
Office Visit - PCP	80%
Office Visit - Specialist	80%
Outpatient Allergy Testing and Treatment	80%
Outpatient Hospice	80%

OPERS Medicare Secondary Plan	
Outpatient Mental Health Care	80%
Outpatient Treatment of Alcohol and Drug Abuse	80%
Outpatient Surgery - including institutional and professional charges	80%
Outpatient Surgery - Ambulatory Surgery Center (including ancillary services)	80%
PREVENTIVE CARE SERVICES (must be billed as preventive)	
<ul style="list-style-type: none"> • Bone Density Testing • Colonoscopy • Sigmoidoscopy • Fecal Occult Blood Test • Mammogram • Pap Test • Physical Examination • Well Child Care 	100%, not subject to the Deductible Frequency, age and gender limitations apply**
Vaccines (For others, please see Preventive Health Care Services) <ul style="list-style-type: none"> • Flu • Human Papillomavirus (HPV) • Pneumonia • Shingles 	100%, not subject to the Deductible Frequency, age and gender limitations apply**
THERAPY SERVICES	
Cardiac Rehabilitation	80%
Chiropractors	80%
Occupational Therapy	80%
Physical Therapy	80%
Speech Therapy	80%
ADDITIONAL SERVICES	
Ambulance	80%
Diabetic Education and Training	80%
Diagnostic Laboratory Testing	100% in a Physician's Office or Independent Lab 80%, all other places of service
Diagnostic Medical Testing and X-rays	80%
Durable Medical Equipment	80%
Home Health Care	80%
Medical Supplies	100%, not subject to the Deductible
Medically Necessary Wigs (after cancer treatment)	80%
Organ Transplant Transportation and Lodging Services (limited to \$10,000 per transplant)	100%, not subject to the Deductible

	OPERS Medicare Secondary Plan
Testing Services <ul style="list-style-type: none"> • Cholesterol Screening • Comprehensive Metabolic Panel • Complete Blood Count (CBC) • EKG (Electrocardiogram) • Electrolyte Panel Screening • Prostate Specific Antigen (PSA) • Urinalysis (UA) 	80% Frequency, age and gender limitations apply**
All Other Covered Services	80%

ALL SERVICES SUBJECT TO MEDICAL NECESSITY. *Waived if admitted. **Please contact Customer Care at the number on your ID card for specific limits or coverage.

INTRODUCTION

Read this Booklet

The best time to learn about your Plan is before you need to use it. That is why it is important to read this booklet. Take a moment to read the HELPFUL NOTES section which follows. Also be sure to read the EXCLUSIONS section. This section will tell you what is NOT covered under the Plan.

- **You must enroll in Medicare the first day you become eligible.** If you or any of your Eligible Dependents are eligible for Medicare but do not enroll, this Plan will not provide coverage for covered Hospital (Medicare A), medical (Medicare B), and/or any other medical expenses.
- If you are a Participant employed by an OPERS-covered employer, you must enroll in medical coverage offered by the public employer. Waiving this employer-sponsored coverage will result in ineligibility under this Plan. If you enrolled in the employer-sponsored coverage, this Plan coordinates coverage as described in the Coordination of Coverage provision. If your employer does not provide health care coverage because those performing similar work or in a similar position are not eligible for employer-sponsored coverage, you are eligible to participate in this Plan.
- Call with questions: Although Medicare and the OPERS Medicare Secondary Plan coverage guidelines may be similar, they are not the same. Even if your treatment is covered by Medicare, it is still a good idea to call Medical Mutual to make certain that coverage is available, and vice versa.

Helpful Notes

We know that health care and health insurance can be hard to understand. Just the size of this booklet says something about how complex it can all be. Although everything in here is important, to make it simpler, we selected some key points for you to remember as you use the OPERS Medicare Plan. You may find it helpful knowing a few basic things.

- This Plan does not cover many types of Nursing Home Care or long-term care, whether in your home or in a nursing home or other facility. It will pay while you are recovering and improving from an illness or Surgery, but it does not pay once you are stable and no longer improving. Do not assume nursing home or in-home care is covered without checking with Medical Mutual first.
- **Keep OPERS up to date on anything that changes, for example, - marriage, divorce, change of address, eligible or becoming Medicare eligible.** It is your responsibility to be certain that OPERS has your current address on file. If OPERS is not made aware of address changes, we cannot guarantee that you will receive important information pertaining to your OPERS account.
- Annual preventive tests, vaccines, and other services listed in this booklet are covered at 100 percent and are not subject to the Plan Deductible as long as the Provider bills these services as preventive. If these tests and services are billed with a medical diagnosis, these tests and services will be covered but subject to your applicable Deductible and Coinsurance. OPERS follows preventive services guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) and Centers for Disease Control (CDC). For a comprehensive list of recommended preventive services, please visit <https://www.uspreventiveservicestaskforce.org/Page/Name/USPSTF-a-and-b-recommendations/>.

DEFINITIONS

Capitalization of words and phrases throughout this document is meant to draw special emphasis to them because they are entries in the definition section.

Alcoholism Or Drug Abuse Residential Treatment Facility - This is an institution that meets all of the following requirements:

- An accredited facility that provides care on a 24 hour a day, 7 days a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders who do not require care in an acute or more intensive medical setting.
- The facility must meet all regional, state and federal licensing requirements.
- Has an on-site licensed Behavioral Health Provider 24 hours/day, 7 days/week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Requires that a patient be admitted by a Physician.
- Has access to Necessary medical services 24 hours/day, 7 days/week.
- Has the availability of on-site medical treatment 24 hours/day, 7 days/week actively supervised by an attending Physician if the participant requires detoxification services.
- Provides living arrangements that foster community living and peer interaction consistent with developmental needs.
- Offers group therapy sessions with at least an RN or master's-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
- Has peer-oriented activities.
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to
 1. meet the Claims Administrator's credentialing criteria as an individual practitioner, and
 2. function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has an individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Has the ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- Has 24 hours/day, 7 days/week supervision by a Physician with evidence of close and frequent observation.
- Has on-site, licensed Behavioral Health Provider, medical or substance abuse professionals 24 hours/day, 7 days/week.

Allowed Amount - For Contracting Providers, the Allowed Amount is the lesser of the applicable Negotiated Amount or Covered Charge. For Non-Contracting Providers, the Allowed Amount is the Non-Contracting Amount, which will likely be less than the Billed Charges.

Approved Clinical Trial - a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or Condition and is described in any of the following:

- A federally funded trial.
- The study or investigation is conducted under an Investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application.

Balance Billing - The amount a Non-Contracted Provider may charge that represents the difference between the Billed Charge and the Allowed Amount determined as payable by Medical Mutual.

Behavioral Health Provider - A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health Conditions.

Benefit Period - the period of time specified in the applicable Plan Features section of this booklet during which Covered Services are rendered, and Deductibles, Coinsurance Maximums and Maximum Out-of-Pockets are accumulated. The first and/or last Benefit Periods may be less than 12 months depending on the Effective Date and the date your coverage terminates.

Billed Charges - The amount billed on the claim submitted by the Provider for services and supplies provided to a Participant.

Board and Room - Charges made by an institution for Board and Room and other Necessary services and supplies. These Charges must be regularly Incurred at a daily or weekly rate.

Case Management - A collaborative, voluntary process that promotes and attempts to facilitate the delivery of the most clinically appropriate care to patients in the most cost-efficient manner.

Charges - The amount a Provider bills for services and supplies before any adjustments for discounts, allowances, incentives or settlements. For a Contracting Institutional Provider in the State of Ohio, Charges are the master charge list uniformly applicable to all payers before discounts, allowances, incentives or settlements.

Claims Administrator - Medical Mutual, who has contracted with OPERS to provide certain administrative services under the Plan.

Coinsurance - A percentage of the Allowed Amount of covered services whereby OPERS and the Participants share in the allowable expense. The Deductible is excluded.

Coinsurance Maximum - A specified dollar amount paid annually by a Participant based on a percentage of the Allowed Amount of Incurred covered services. Annual Deductible, Copays and any Excess Charges do not count toward the Participant's Coinsurance Maximum. The Coinsurance Maximums are shown in the applicable Plan Features section of this booklet.

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

Confinement Period - the period of time beginning when you enter a Skilled Nursing Facility and ending when you have been out of the Skilled Nursing Facility for 90 days.

Contract - The agreement between Medical Mutual and OPERS to administer the Plan.

Contracting - A Hospital, Physician, Covered Provider or Other Facility Provider is Contracting if it has an agreement with Medical Mutual about payment for Covered Medical Expenses.

Contracting Institutional Provider - A Hospital or Other Facility Provider who has an agreement with Medical Mutual regarding payment for Covered Medical Expenses or is designated by Medical Mutual as Contracting.

Copayment (Copay) - The amount a Participant pays for a Covered Medical Expense. Your Copayments are shown in the Plan Features section of this booklet.

Covered Charges - the Billed Charges for Covered Services, except that Medical Mutual reserves the right to limit the amount of Covered Charges for Medical Expenses provided by a Non-Contracting Provider to the Non-Contracting Amount determined as payable by Medical Mutual.

Covered Medical Expenses - The expenses for certain Hospital and other medical services and supplies. They must be for the treatment of a Condition. A complete list of Covered Medical Expenses is shown in this booklet. Even though Medical Mutual determines that services are justified and appropriate, no Charges will be payable for Covered Medical Expenses if they are listed in the Exclusions section of this booklet.

Covered Provider - The following practitioners or entities that are legally qualified and licensed and/or certified as required by law will be considered a Covered Provider:

- Dentist;
- Doctor of chiropractic medicine;
- Durable medical equipment or prosthetic appliance vendor;
- Home health;
- Hospital;
- Laboratory (must be Medicare Approved);

- Licensed Clinical Mental Health Counselor
- Licensed dietician;
- Licensed Practical Nurse (L.P.N.);
- Licensed Professional Counselor (L.P.C.);
- Mechanotherapist (if licensed or certified in Ohio);
- Nurse-midwife;
- Occupational therapist;
- Other Facility Provider;
- Physical therapist;
- Physician;
- Podiatrist;
- Professional ambulance service;
- Psychologist;
- Registered Nurse (R.N.); and
- Urgent Care Provider.

Certain Covered Providers may not bill on their own behalf. They are required by licensing standards to be under the employment or supervision of a Physician.

Custodial Care - Services and supplies furnished mainly to help a person in the activities of daily life. Custodial Care includes Board and Room and other Institutional care. The person does not have to be disabled. Such services and supplies are custodial regardless of who prescribes or recommends them, or how and by whom they are performed. Custodial Care is not a covered service.

Deductible - The amount of Covered Medical Expenses each Participant pays per Benefit Period before Charges are paid. Your Deductible is shown in the Plan Features section of this booklet.

Diagnosis Related Groups (DRG) - A method for identifying a course of treatment commonly associated with a specific diagnosis or Condition.

Durable Medical and Surgical Equipment - This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature;
- Not for exercise or training.

Not included is equipment such as: whirlpools, portable whirlpool pumps, sauna baths, massage devices, over-bed tables, elevators, communication aids, vision aids and telephone alert systems.

Effective Date - 12:01 a.m. on the date when your health care coverage begins, as determined by OPERS.

Effective Treatment of Alcoholism or Drug Abuse - A program of alcoholism or drug abuse therapy prescribed and supervised by a Physician. It must either:

- Have a follow-up therapy program, directed by a Physician, on at least a monthly basis; or
- Include meetings at least twice a month with organizations devoted to alcoholism or drug abuse treatment.

The following are not considered effective treatment:

- Detoxification without a specified follow-up therapy program; or
- Maintenance care. This means providing an environment free of alcohol or drugs.

Eligible Benefit Recipient - A Medicare eligible Individual who is receiving, a monthly benefit payment from OPERS and is eligible to be enrolled in the Plan as determined by OPERS.

Eligible Dependent - The Eligible Benefit Recipient's Medicare Eligible spouse or child(ren) or sponsored dependent(s), who is eligible to be enrolled in the Plan as determined by OPERS.

Emergency Admission - When a Physician admits the person to the Hospital or treatment facility right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental Condition that:

- Requires confinement right away as a full-time Inpatient; and
- If immediate Inpatient care was not given could, as determined by Medical Mutual, reasonably be expected to result in:
 1. Placing the person's health in serious jeopardy;
 2. Serious impairment to bodily function;
 3. Serious dysfunction of a body part or organ; or
 4. In the case of a pregnant woman, serious jeopardy to the health of the fetus or embryo.

Emergency Medical Condition - a medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to the individual's bodily functions; or
- Serious dysfunction of a bodily organ or part of the individual.

Emergency Room Copayment - A fee you pay each time you visit a Hospital emergency room. It does not apply if you are admitted to the Hospital within 24 hours after an emergency room visit. This Copayment amount applies to the Charge for use of the emergency room facility only.

Emergency Services - a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

Essential Health Benefits - Defined under the federal law (the Patient Protection and Affordable Care Act (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 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.

Excess Charges - The amount of Billed Charges, less Non-covered Charges, in excess of the Allowed Amount determined as payable by Medical Mutual for a Non-contracting Provider.

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

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is provided; or
- if reliable evidence shows that the drug, device, medical treatment or procedure is not considered to be the standard of care, is the subject of ongoing 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 is that the drug, device, medical treatment or procedure is not the standard of care and that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis.

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

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

- corporate medical policies developed by Medical Mutual; or
- any other findings, studies, research and other relevant information published by government agencies and nationally recognized organizations.

Even if a drug, device, or portion of a medical treatment or procedure is determined to be Experimental or Investigational, the Plan will cover those Medically Necessary services associated with the Experimental or Investigational drug, device, or portion of a medical treatment or procedure that the Plan would otherwise cover had those Medically Necessary services been provided on a non-Experimental or non-Investigational basis.

The determination of whether a drug, device, medical treatment or procedure is Experimental or Investigational shall be made by the Plan and Medical Mutual in their sole discretion, and that determination shall be final and conclusive, subject to any available appeal process.

Gender Dysphoria - The discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth. Medical treatment includes feminization (male-to-female or MtF) or masculinization (female-to-male or FtM) of the body through hormone therapy and/or surgery, and psychotherapy including counseling and support. Gender reassignment surgery (transsexual surgery or sex reassignment surgery) refers to surgical procedures for the treatment of Gender Dysphoria.

Home Health Care Agency - An agency that meets all the following criteria:

- Provides mainly skilled nursing and other therapeutic services;
- Is associated with a professional group that makes policy. This group must have at least one Physician and one R.N.;
- Has full-time supervision by a Physician or an R.N.;
- Keeps complete medical records on each person;
- Has a full-time administrator;
- Meets licensing standards; and
- Submits Charges.

Home Health Care Plan - A plan that provides for continued care and treatment of a Condition. The care and treatment must be:

- Prescribed in writing by the attending Physician; and
- An alternative to staying in the Hospital or Skilled Nursing Facility.

Hospice Care - Care given to a Terminally Ill Person by, or under arrangements with, a Hospice Care Agency. The care must be part of a Hospice Care Program.

Hospice Care Agency - An agency or organization that:

- Has Hospice Care available 24 hours a day;
- Meets any licensing or certification standards set forth by local jurisdiction;
- Provides skilled nursing services, medical social services, psychological and dietary counseling and bereavement counseling for the Immediate Family;
- Provides, or arranges for, other services, including:
 1. Services of a Physician;
 2. Physical or occupational therapy;
 3. Part-time home health aide services that consist mainly of caring for Terminally Ill persons; and
 4. Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel that includes at least one:
 1. Physician;
 2. R.N.;
 3. Licensed or certified social worker employed by the agency; or other counselor.
- Establishes policies governing the provision of Hospice Care;
- Assesses the patient's medical and social needs;
- Develops a Hospice Care Program to meet those needs;

- Provides an ongoing quality assurance program, including reviews by Physicians other than those who own or direct the agency;
- Permits all area medical personnel to utilize its services for their patients;
- Keeps a medical record on each patient;
- Utilizes volunteers trained in providing services for non-medical needs;
- Has a full-time administrator; and
- Submits Charges.

Hospice Care Program - Hospice Care that:

- Is established by and reviewed from time to time by a Physician attending the person and appropriate personnel of a Hospice Care Agency;
- Is designed to provide palliative and supportive care to Terminally Ill persons and supportive care to their families; and
- Includes an assessment of the person's medical and social needs and a description of the care to be given to meet those needs.

Hospice Facility - A facility, or distinct part of one, that:

- Provides mainly Inpatient Hospice Care to Terminally Ill persons;
- Charges its patients;
- Meets any licensing or certification standards set forth by local jurisdiction;
- Keeps a medical record on each patient;
- Provides an ongoing quality assurance program, including reviews by Physicians other than those who own or direct the facility;
- Is run by a staff of Physicians, one of whom must be on call at all times;
- Provides 24 hours/day, 7 days/week nursing services under the direction of an R.N.; and
- Has a full-time administrator.

Hospital - An institution that meets all of the following criteria:

- Provides mainly Inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons;
- Is supervised by a staff of Physicians;
- Provides R.N. services 24 hours/day, 7 days/week;
- Is not a place mainly for rest, for the aged, for drug addicts, for alcoholics or a nursing home;
- Submits Charges; and
- Meets all licensing standards.

Hospital Inpatient Copayment - The part of your expenses you pay each time you are in the Hospital. The Hospital Admission Deductible applies just once to all Hospital stays for the same or related cause as long as they are 60 days or less apart. Expenses used to meet the Hospital Admission Deductible cannot be used to meet any other Deductible that applies.

Immediate Family - You and your spouse, parents, stepparents, grandparents, nieces, nephews, aunts, uncles, cousins, brothers, sisters, children and stepchildren by blood, marriage or adoption.

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

Inpatient - A Participant who receives care as a registered bed patient in a Hospital or Other Facility Provider where a Board and Room Charge is made.

Life-threatening Condition - any disease or Condition from which the likelihood of death is probable unless the course of the disease or Condition is interrupted.

L.P.N. - A Licensed Practical Nurse.

Maintenance Care - Services or supplies that are furnished principally to maintain rather than improve a level of physical or mental function or to provide a protected environment free from exposure that can worsen the Participant's physical or mental Condition.

Maximum Out-of-Pocket - a specified dollar amount of Deductible, Coinsurance and Copayment expense Incurred in a Benefit Period by a Participant for Covered Medical Expenses.

Medical Care - Professional services received from a Covered Provider to treat a Condition.

Medical Plan Description - (MPD) This booklet, which describes the coverage available under the Plan.

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

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

Medicare Secondary Plan (the Plan) - The coverage OPERS sponsors for Eligible Benefit Recipients and Eligible Dependents: until Eligible Benefit Recipients have completed their initial open enrollment into an individual Medicare plan through the OPERS Medicare Connector; for Eligible Benefit Recipients who are not participating in the OPERS' health reimbursement arrangement plan, as determined by OPERS; and. Re-employed Eligible Benefit Recipients who are Medicare eligible. The Plan pays secondary to Medicare, as applicable, and to any other coverage in which a Participant is enrolled.

Mental Disorder - A disease commonly understood to be a Mental Disorder - whether or not it has a physiological or organic basis - and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, psychologist or psychiatric social worker. A Mental Disorder includes but is not limited to:

- Alcoholism and drug abuse;
- Schizophrenia;
- Bipolar disorder;
- Panic disorder;
- Major depressive disorder;
- Psychotic depression; and
- Obsessive-compulsive disorder.

For the purposes of coverage under this Plan, Mental Disorder will include alcoholism and drug abuse only if any separate coverage for a particular type of treatment does not apply to alcoholism and drug abuse.

Necessary - A service or supply furnished by a particular Provider is Necessary if Medical Mutual determines that it is appropriate for the diagnosis, care or the treatment of the Condition involved.

To be appropriate, the service or supply must:

- Be care or treatment that is as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Condition involved and the Participant's overall health Condition;
- Be a diagnostic procedure, indicated by the health status of the Participant, that is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Condition involved and the Participant's overall health Condition; and
- Be no more costly as to diagnosis, care and treatment (taking into account all health expenses Incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Medical Mutual will consider:

- Information provided on the affected Participant's health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- Professional standards of safety and effectiveness generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Medical Mutual's attention.

In no event will the following services or supplies be considered to be Necessary:

- Those furnished mainly for the personal comfort or convenience of:

1. The Participant;
 2. Any person who cares for him or her;
 3. Any person who is part of his or her family; or
 4. Any healthcare Provider or healthcare facility.
- Those furnished solely because the Participant is an Inpatient on any day on which the Participant's Condition could safely and adequately be diagnosed or treated while not confined; or
 - Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a less costly setting.

Negotiated Amount - the amount the Provider has agreed with Medical Mutual to accept as payment in full for Covered Services, subject to the limitations set forth below.

The Negotiated Amount may include performance withholds and/or payments to Providers for quality or wellness incentives that may be earned and paid at a later date. Your Copayment, Deductible and/or Coinsurance amounts may include a portion that is attributable to a quality incentive payment or bonus and will not be adjusted or changed if such payments are not made.

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

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

Non-Contracting - The status of a Provider that does not have an agreement with Medical Mutual about payment for Covered Medical Expenses.

Non-Contracting Amount - subject to applicable law, the maximum amount allowed by Medical Mutual for Covered Services provided to covered Participants by a Non-Contracting Provider based on various factors, including, but not limited to, market rates for that service, Negotiated Amounts for that service, and Medicare reimbursement for that service. The Non-Contracting Amount will likely be less than the Provider's Billed Charges. If you receive services from a Non-Contracting Provider, and you are balanced billed for the difference between the Non-Contracting Amount and the Billed Charges, you may be responsible for the full amount up to the Provider's Billed Charges, even if you have met your Maximum Out-of-Pocket.

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

Non-Urgent Admission - A Hospital admission that is not an Emergency Admission or an Urgent Admission.

Orthodontic Treatment - Any medical or dental service or supply furnished to prevent, diagnose or correct a misalignment of the teeth, bite, jaws or jaw-joint relationships, whether or not for the purpose of relieving pain. It does not include the installation of a space maintainer or a surgical procedure to correct malocclusion.

Other Facility Provider - Institutions that are licensed, when required, and where covered services are rendered that require compensation from their patients. Other than incidentally, these facilities are not used as offices or clinics for the private practice of a Physician or Covered Provider. Medical Mutual will provide coverage only for services or supplies for which a Charge is made. Other Facility Providers include but are not limited to Alcoholism and Drug Abuse Treatment Facilities, Home Health Care Agencies and Skilled Nursing Facilities.

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

Participant - A Participant or Eligible Dependent, as determined by OPERS, who is enrolled in this Plan. The terms "you" and "your" also refer to Participant in this booklet.

Payment Percentage - After any applicable Deductible, healthcare Charges are paid at the Payment Percentage that applies to Covered Medical Expenses Incurred.

Physician - A person licensed to practice medicine.

PPACA - Patient Protection and Affordable Care Act. A United States federal statute signed into law on March 23, 2010.

Primary Care Provider (PCP) - a Physician, group of Physicians, certified nurse practitioner, Physician assistant or advanced practice nurses trained in family practice, general practice, geriatrics, internal medicine, pediatrics, psychiatry, psychology, neonatology, obstetrics or gynecology.

Professional Ambulance - A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Provider - A Hospital, Physician, Covered Provider or Other Facility Provider.

Provider's Rate - For Contracting Providers, the Provider's Rate is the Negotiated Amount. For Non-Contracting Providers, the Provider's Rate is the Non-Contracting Amount, which will likely be less than the Provider's Billed Charges.

R.N. - A Registered Nurse.

Routine Patient Costs - all healthcare services that are otherwise covered under the Plan for the treatment of cancer or other Life-threatening Condition that is typically covered for a patient who is not enrolled in an Approved Clinical Trial.

Semi-private Rate - The Charge for Board and Room that an institution applies to the majority of beds in semi-private rooms with two or more beds. If there are no such rooms, Medical Mutual will determine the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Care - Care that requires the skill, knowledge or training of a Physician or of a Registered Nurse, Licensed Practical Nurse or physical therapist performed under the supervision of a Physician. In the absence of such care, the Participant's health would be seriously impaired.

Skilled Nursing Facility - An institution that meets all the following criteria:

- Is licensed to provide, and does provide, the following services on an Inpatient basis for persons convalescing from a Condition:
- Professional 24 hours/day, 7 days/week nursing care by an R.N. or L.P.N. and directed by a full-time R.N.; and
- Physical restoration services to help patients meet a goal of self-care in daily living activities (such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or using the toilet);
- Is supervised full time by a Physician or R.N.;
- Keeps a complete medical record on each patient;
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for persons with intellectual disability, for Custodial Care or educational care, or for care of Mental Disorders; and
- Submits Charges.

Specialist - a Physician, group of Physicians, certified nurse practitioner, Physician assistant or advanced practice nurses in other than family practice, general practice, geriatrics, internal medicine, pediatrics, psychiatry, psychology, neonatology, obstetrics or gynecology.

Stabilize - with respect to an Emergency Medical Condition, to provide such medical treatment of the 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.

Subject of a Clinical Trial - the healthcare service, item, or drug that is being evaluated in the Approved Clinical Trial and that is not a Routine Patient Cost.

Surgery - Is defined as:

- Performance of generally accepted operative and other invasive procedures;
- Correction of fractures and dislocations;
- Usual and related preoperative and postoperative care; or
- Other procedures as reasonably approved by Medical Mutual.

Surgery Center - A freestanding ambulatory surgical facility that:

- Meets licensing standards;
- Is set up, equipped and operated to provide surgical services;
- Submits Charges;
- Is directed by a staff of Physicians, one of whom must be on the premises when Surgery is performed and during the recovery period;

- Has at least one certified anesthesiologist on the premises when Surgery requiring general or spinal anesthesia is performed and during the recovery period;
- Extends surgical staff privileges to Physicians who practice Surgery in an area Hospital and Dentists who perform oral Surgery;
- Has at least two operating rooms and one recovery room;
- Provides, or arranges with a medical facility in the area, for diagnostic X-ray and lab services needed in connection with Surgery;
- Does not have a place for patients to stay overnight;
- Provides, in the operating and recovery rooms, full-time Skilled Nursing Care directed by an R.N.;
- Is equipped and has trained staff to handle medical emergencies;
- Has a:
 1. Physician trained in cardiopulmonary resuscitation;
 2. Defibrillator;
 3. Tracheotomy set; and
 4. Blood volume expander.
- Has a written agreement with a Hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them;
- Provides an ongoing quality assurance program, including reviews by Physicians who do not own or direct the facility; and
- Keeps a medical record on each patient.

Terminally III - A medical prognosis of six months or less to live.

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

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

Urgent Admission - An admission to the Hospital because of the onset of or a change in a disease, or the diagnosis of a Condition caused by an accident that, while not needing an Emergency Admission, is severe enough to require confinement as an Inpatient in a Hospital within two weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider - A Covered Provider that performs services for health problems that require immediate medical attention but are not emergencies.

Women's Health and Cancer Rights Act - The Women's Health and Cancer Rights Act of 1998 became effective on October 21, 1998. It applies to women who want to have a breast reconstruction for a breast that was lost due to cancer. The act states that health plans must cover reconstructive breast Surgery if they cover mastectomy (removal of a breast). The Plan must cover:

- Reconstruction of the breast that was removed;
- Surgery and reconstruction of the other breast for a balanced look; and
- Prostheses (false breast) and treatment of problems resulting from the breast removal Surgery, including lymphedemas.

Medical Mutual will work with the patient and the patient's Physician to decide how Charges will be paid. The Plan's regular Copayments and Deductibles will apply to these Charges.

ENROLLMENT PROVISIONS

The Effective Date of coverage will be determined by OPERS. When you enroll, there may be a waiting period before coverage can become effective. Contact OPERS for complete enrollment guidelines.

Employment with an OPERS-covered employer further controls the Plan in which you are eligible to enroll.

No Participant may be covered both as an Participant and Eligible Dependent or as an Eligible Dependent of more than one Participant. OPERS will not be the responsible system for healthcare coverage for those retirees or dependents of retirees who waive coverage, or who become eligible for coverage from another Ohio Retirement System (State Teachers Retirement System, Ohio Police & Fire Pension Fund, School Employees Retirement System of Ohio or State Highway Patrol Retirement System) after January 1, 2007. OPERS' coverage can be chosen as secondary coverage, however, as long as eligibility requirements for the OPERS Medicare Plan are met.

If you will be residing at a different location on a permanent or seasonal basis, you will need to contact OPERS with your address correction.

If you are an Inpatient when coverage is effective, the plan covering you upon admission continues to be the primary payer until you are discharged.

Open Enrollment

Each fall, you have the opportunity to enroll in the Plan. You may enroll yourself and/or your Eligible Dependents during the open enrollment period for coverage effective January 1 of the following year.

Outside of Open Enrollment

You may enroll in the Plan outside of annual open enrollment when you become an Eligible Benefit Recipient for the Plan including re-employment with an OPERS-covered employer and ESRD.

Eligible Dependents

In accordance with the Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code, a Participant who, receives a monthly age and service retirement or disability benefit, may enroll:

- Your legal spouse. You must provide a valid marriage certificate recognized by Ohio law and valid proof of birth.
- Your biological or legally adopted child or minor grandchild if the grandchild is born to an unmarried, un-emancipated minor child and you are ordered by the court to provide coverage pursuant to Ohio Revised Code, section 3109.19. You must provide valid proof of birth for the child.

In order for a child to be eligible for coverage, the child must be younger than age 26. This Plan will cover your married or unmarried child until your child reaches age 26, unless your child is eligible to enroll in an employer sponsored health plan, other than a group health plan of a parent. Coverage may be extended if the child is permanently and totally disabled prior to age 22. This means that the child is not able to work in any substantial gainful activity because of a physical or mental impairment which has lasted or is expected to last for at least 12 months. Evidence of the incapacity is required and is subject to approval by OPERS.

A Participant who is a survivor benefit recipient may enroll the deceased OPERS member's minor Eligible Dependents. If the Eligible Dependent becomes an Eligible Benefit Recipient, he or she may enroll in the Plan.

You must notify OPERS in writing, within 30 days of the date your Eligible Dependent no longer meets eligibility requirements and indicate the date your dependent is no longer eligible. Monthly premium payments do not guarantee coverage if your dependent no longer meets the eligibility requirements. Failure to notify OPERS could result in overpaid healthcare claims for which you will be responsible.

Incapacitated Children

To qualify as an incapacitated child, an individual must be unmarried and meet the following criteria:

The unmarried child has a mentally or physically disabling Condition that was confirmed by a qualified Physician as beginning prior to the child reaching age 22.

Eligibility Date for Coverage

The date you are eligible for coverage under the Plan. OPERS determines this date.

Enrolling Eligible Dependents

You may enroll your Eligible Dependents at the time of your retirement or:

- In the event your Eligible Dependent is covered under another health plan and is involuntarily terminated, or that Eligible Dependent is newly qualified by certain events including but not limited to marriage, birth or adoption, and the application is received with all required supporting documentation within 60 days of the event. Coverage will start no later than 31 days from the date OPERS receives the application.
- During an open enrollment period. Coverage will begin the following January 1.

Medicare Eligibility

The month you or your spouse are enrolled in Medicare Parts A and B, you will have the option to enroll in an individual Medicare plan through OPERS' Medicare Connector administered by Via Benefits.

High-Deductible Health Plans (HDHPs)

Federal law prohibits retirees from being covered by the OPERS healthcare plan as secondary coverage to an employer's high-deductible health plan (HDHP) and a health savings account (HSA). (For more information about federal limitations regarding participation in an HDHP/HSA and an employer health plan, please consult the left column of page 4 of IRS Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans under "Other health coverage.")

Pre-existing Conditions

There are no pre-existing Condition limitations under the Plan. A Participant may enroll in coverage regardless of their current or past medical Condition(s).

Voluntary Withdrawal from the Plan

Beginning January 1, 2014, retirees who voluntarily elect to withdraw from the Plan may only re-enroll with proof of creditable coverage in another healthcare plan. With proof of creditable coverage, retirees may re-enroll during the annual open enrollment period or within 60 days of involuntary termination of healthcare coverage under another plan. Documentation of the termination is required.

Returning to Work after Retirement

Re-employment is returning to employment with an OPERS-covered employer during retirement. Re-employed retirees are not eligible to participate in the HRA. Rather, re-employed retirees may be eligible to participate in this Plan. Upon re-employment, you may enroll in this Plan and provide information about the employer-sponsored coverage described below.

OPERS-covered employers must notify OPERS of your employment by the end of the month following your return to work. The employer must also provide your primary health care coverage during re-employment if it provides coverage to other employees performing comparable work or in a comparable position. If you choose to enroll in your employer's coverage, the employer's coverage is primary and OPERS coverage pays secondary to the employer's coverage. If you do not enroll in the employer's available coverage, you are not eligible to participate in this Plan unless you also procure other primary coverage, for example, as a dependent on your spouse's employer coverage. If your OPERS-covered employer does not provide you with health care coverage, you can enroll in this Plan until your public employment ends. Please contact OPERS to discuss your options when your public employment ends.

DESCRIPTION OF COVERAGE

General Information About What Is Paid And For What Period

This Plan covers expenses, not a disease or injury itself. This means the Plan pays only for expenses you have while the coverage is in effect. No payments are made for expenses you had before coverage started or will have after coverage ends. This is true even if you had expenses because of an accident, injury or disease that happened, started or was going on while coverage was in effect.

If a Plan rule allows for coverage to continue, the above will not apply for expenses after coverage has terminated.

When a Charge is made to you for a service or supply, it is "Incurred." A Charge is Incurred on the day you receive the service or supply. If one Charge is made for a series of services, a "pro-rata" Charge is figured for each. Medical Mutual will determine the pro-rata Charge. This means the Charge is broken down into equal parts. This is not done if your bill or other proof shows the Charge for each service.

Neither OPERS nor Medical Mutual assumes any responsibility for the outcome of any covered services or supplies and makes no express or implied warranties concerning the outcome of any covered services or supplies.

COMPREHENSIVE MEDICAL EXPENSE COVERAGE

Comprehensive Medical Expense Coverage is merely a name for the coverage in this section. This term does not mean all medical expenses are covered. There are Exclusions, Deductibles and Copayments you must pay. These are all described in this booklet. All Covered Medical Expenses must be Necessary, unless otherwise specified.

The Plan Features section of this booklet outlines the Payment Percentages for the main types of Covered Medical Expenses. These covered expenses are described on the following pages.

After any applicable Deductible, health expenses are paid at the Coinsurance level that applies to the Covered Medical Expenses Incurred.

The following are Covered Medical Expenses:

Alcoholism and Drug Abuse

Inpatient Treatment

If a Participant is confined in a Hospital or Alcoholism or Drug Abuse Residential Treatment Facility, the expenses Incurred for detoxification are covered, but only if the detoxification is for the effective treatment of the underlying causes leading to rehabilitation from the addiction (e.g., cirrhosis of the liver, delirium tremens or hepatitis). Inpatient care must be approved by Medical Mutual prior to admission.

See also: "Certification for Other Services" later in this section.

Outpatient Treatment

If a Participant is not an Inpatient in either a Hospital or in an Alcoholism or Drug Abuse Treatment Facility, expenses for the Effective Treatment of Alcoholism or Drug Abuse are covered. The Charges will be paid at the Payment Percentage shown in the Plan Features section of this booklet.

The coverage also shows the limit on how much the Plan will pay for each Participant.

Effective Treatment of Alcoholism and Drug Abuse is explained in the Definitions section.

Allergy Tests and Treatment

Allergy tests that are performed and related to a specific diagnosis are Covered Medical Expenses. Allergy shots also are covered.

Ambulance Services

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

Covered transportation:

- from the scene of an accident or Emergency Medical Condition to the closest Hospital to provide Emergency Services;
- from one Hospital to another Hospital, including when we require a Participant to move from a Out-of-Network Provider to a In-Network Provider;
- from a Hospital or a Skilled Nursing Facility to your home or to another facility, if an ambulance is the only safe way to transport you;
- from your home to a Hospital, if an ambulance is the only safe way to transport you;

- When during a covered Inpatient stay at a Hospital, Skilled Nursing Facility or acute rehabilitation Hospital, an ambulance is required to safely and adequately transport you to or from Inpatient or Outpatient Necessary treatment.

It's important to note:

- Ambulance services are a Covered Medical Expense only when the Participant's Condition is such that use of any other method of transportation could endanger the Participant's health.
- Covered Medical Expenses include treatment of a sickness or injury by medical Professionals from an ambulance service when you are not transported, if Medically Necessary.
- Transportation for Emergency Medical Conditions will also be covered when provided by a professional ambulance service for other than local ground transportation, such as air and water transportation, only when special treatment is required and the transportation is to the nearest Hospital qualified to provide the special treatment.
- Transportation for Conditions other than Emergency Medical Conditions via ambulance are a Covered Medical Expense only when Necessary and certified by a Physician, except:
 - when a Participant is required by Medical Mutual to move from an Out-of-Network Provider to an In-Network Provider; or
 - when ordered by an employer, school, fire or public safety official, and the Participant is not in a position to refuse.

Non-covered services for ambulance include, but are not limited to, trips to a Physician's office clinic, a morgue or a funeral home. Transportation services provided by an ambulance or a wheelchair van are also not a Covered Medical Expense.

Clinical Trial Programs

Coverage is provided for Routine Patient Costs administered to a Participant participating in any stage of an Approved Clinical Trial, if that care would be covered under the Plan if the Participant was not participating in a clinical trial.

In order to be eligible for coverage, the Participant must meet the following conditions (number 2 below is not required for cancer clinical trials in Ohio):

1. The Participant is eligible to participate in an Approved Clinical Trial, according to the trial protocol with respect to treatment of cancer or other Life-threatening Conditions.
2. Either:
 - a. The referring Provider is a Contracting Provider and has concluded that the Participant's participation in such trial would be appropriate based upon the Participant meeting the conditions described above; or
 - b. The Participant provides medical and scientific information establishing that his or her participation in such trial would be appropriate based upon the Participant meeting the conditions described above.

If the clinical trial is not available from a Contracting Provider, the Participant may participate in an Approved Clinical Trial administered by a Non-Contracting Provider. However, the Routine Patient Costs will be covered at the Non-Contracting Amount, and the Participant may be subject to Balance Billing up to the Provider's Billed Charges for the services.

There is no coverage for the following:

- A healthcare service, item, or drug that is the subject of the Approved Clinical Trial;
- A healthcare service, item, or drug provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the Approved Clinical Trial;
- An item or drug provided by the Approved Clinical Trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by an entity other than Medical Mutual, including the sponsor of the Approved Clinical Trial;
- A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Diagnostic Services

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

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

Emergency Services

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

In the event of an emergency:

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

Care and treatment once you are Stabilized are not Emergency Services. Continuation of care beyond that needed to evaluate or Stabilize your Emergency Medical Condition will be covered according to the provisions in this document.

Gender Dysphoria Treatment

The Plan will cover Medically Necessary services for the treatment of gender dysphoria, subject to accepted medical clinical guidelines and corporate medical policies.

Home Health Care

Charges made by an R.N., an L.P.N. or by a nursing agency for "Skilled Nursing Care." Skilled Nursing Care is considered part or all of any nursing care that requires the education, training or technical skills of an R.N. or L.P.N.

Home health care expenses also are covered if the charge is made by a Home Health Care Agency, the care is given under a Home Health Care Plan and the care is given to a Participant in his or her home.

Covered Medical Expenses for home health care include:

- Visiting nurse care by an R.N. or if an R.N. is not available, by an L.P.N.. Visiting nurse care means a visit of not more than four hours for the purpose of performing specific skilled nursing tasks.
- Care provided solely for skilled observation for up to one, four-hour period per day for a period of no more than 10 consecutive days following:
 - Change in patient medication;
 - Need for treatment of an emergency Condition by a Physician or the onset of symptoms indicating the likely need for such treatment;
 - Surgery; or
 - Release from Inpatient confinement.
- Part-time or intermittent home health aide services for patient care when provided in conjunction with skilled services;
- Physical, occupational and speech therapy;
- Services of a licensed medical social worker provided in conjunction with covered nursing or therapy services; and
- The following to the extent they would have been covered under this Plan if the Participant had been confined in a Hospital or Skilled Nursing Facility:

- Medical supplies, drugs and medicines prescribed by a Physician;
 - Lab services provided by or for a Home Health Care Agency; and
 - Oxygen and its administration.
- Injectable prescription drugs administered by a covered Provider.

Each visit by a nurse or therapist is one visit. Each visit of up to four hours by a home health aide is one visit.

Limitations to Home Health Care Expenses

The Plan does not cover:

- Care provided to help a Participant in the activities of daily living. Examples are bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or using the toilet;
- Any service just for giving oral medicines. This does not apply if the law states that the medicines must be given by an R.N. or L.P.N.;
- Services of a Participant who usually lives with or is a member of the family;
- Dietitian services;
- Transportation;
- Food or home-delivered meals; and
- Custodial Care, rest care, or care that is only for someone's convenience.

Hospice Care

Charges made for the following services furnished to a Participant when they are part of the Hospice Care Program:

Facility Expenses

The Charges made on its own behalf by a:

- Hospice Facility;
- Hospital; or
- Skilled Nursing Facility

For:

- Board and Room and other services and supplies furnished to a Participant while a full-time Inpatient for:
 - Pain control;
 - Other acute and chronic symptom management; and
 - Respite care
 - When the Participant's family or usual caretaker cannot, or will not, attend to the Participant
 - Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These services consist mainly of caring for the Participant;
- Medical supplies, drugs and medicines prescribed by a Physician;
- Oxygen and its administration; and
- Bereavement counseling.

Charges Made by Providers

Charges made by the Providers below are considered Covered Medical Expenses only if the Provider is not an employee of a Hospice Care Agency and such agency retains responsibility for the care of the Participant:

- A Physician for consultant or case-management services; or
- A physical or occupational therapist.

Home Health Care Agency

The following Charges made by a Home Health Care Agency are considered Covered Medical Expenses:

- Physical or occupational therapy;
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These services consist mainly of caring for the Participant;
- Medical supplies, drugs and medicines prescribed by a Physician; and psychological and dietary counseling needs.

Other Expenses

The following Charges made by a Hospice Care Agency are considered Covered Medical Expenses:

- Bereavement counseling;
- Consultation or Case Management services by a Physician;
- Medical social services under the direction of a Physician, including:
 - Assessment of the Participant's social, emotional and medical needs, and the home and family situation;
 - Identification of community resources available to the Participant; and
 - Assisting the Participant to obtain those resources needed to meet the Participant's assessed needs.
- Oxygen and its administration;
- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours in any one day; and
- Psychological and dietary counseling.

Limitations to Hospice Care Expenses

The Plan does not cover:

- For Facility Expenses, the Plan does not cover any Charge for daily Board and Room in a private room over the semiprivate rate; this is shown in the Plan Features section of this booklet. Hospice Coverage is unlimited;
- Services and supplies given to a Participant who is not a full-time Inpatient;
- Funeral arrangements;
- Pastoral Counseling;
- Financial or legal counseling, including estate planning or the drafting of a will;
- Homemaker or Caretaker services not directly related to the patient's care. Examples are sitter or companion services for the patient or other family members, transportation, housecleaning and fixing things around the house.
- Respite care provided when the Participant is not staying in the Hospice Facility full-time; Charges for more than one item of equipment used for the same or similar purpose;
- Volunteer Services;
- Food or home-delivered meals;
- Chemotherapy or radiation therapy if other than to relieve the symptoms of a Condition.

Hospital Expenses

Inpatient Expenses

Inpatient services are provided to a Participant who is staying overnight in the Hospital. The Plan covers expenses made by a Hospital for:

- Board and semi-private Room, unless a private Room is Necessary (if a semi-private Room is not available, the Plan will cover a private room); and
- Other Hospital services and supplies.

There is no limit on the number of days of confinement.

Covered Medical Expenses include:

Ancillary Services

- Operating, delivery and treatment rooms and equipment;

- Prescription drugs;
- Whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing;
- Anesthesia, anesthesia supplies and services;
- Oxygen and other gases;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic services;
- Therapy services;
- Surgically inserted prosthetics such as pacemakers and artificial joints; and
- Inpatient cardiac rehabilitation.

Concurrent Care

Care by two or more Physicians during one Hospital stay. While you are in the Hospital for Surgery, you are covered for care by a Physician who is not your surgeon for an unrelated medical Condition.

Inpatient Medical Care Visits

The examinations given to you by your Physician or Covered Provider while you are in the Hospital.

Inpatient Consultation

A bedside examination by another Physician or Covered Provider when requested by your attending Physician.

Intensive Medical Care

Constant medical attendance and treatment when your Condition requires it.

Newborn Exam

Inpatient medical care visits to examine a newborn if the newborn has been enrolled in the healthcare Plan. Contact OPERS for enrollment information.

Private Room

When Necessary as a result of third-degree burns or a communicable disease requiring isolation for medical reasons. If you request a private room and it is not determined to be Necessary, Medical Mutual will provide coverage only for the Hospital's average semi-private room rate. If a semi-private room is not available, the Plan will cover a private room.

Outpatient Expenses

Outpatient expenses include Charges made by a Hospital or Surgery Center, on its own behalf, for the following Outpatient services that are furnished to a Participant while not confined as a fulltime Inpatient:

- Services furnished on the day of and in connection with a surgical procedure involving cutting or the reduction of a dislocation or fracture; or
- Emergency treatment furnished for a Condition on the day of the injury or illness.
- Diagnostic Services

Preadmission Testing Expenses

Preadmission testing expenses include Charges made by a Hospital or Surgery Center, on its own behalf, before a Participant has scheduled Surgery. The Plan covers tests if they are done while a Participant is an Outpatient, and:

- Tests are related to the scheduled Surgery;
- Tests are done within 10 days prior to the scheduled Surgery;
- Participant undergoes the scheduled Surgery in a Hospital or Surgery Center. This does not apply if the tests show that Surgery should not be done because of the Participant's physical Condition;
- Charge for the Surgery is a Covered Medical Expense under this Plan;
- Tests are done while the Participant is not confined as an Inpatient in a Hospital. The Charges for the tests would have been covered if the Participant was confined as an Inpatient in a Hospital;
- Test results appear in the Participant's medical record kept by the Hospital or Surgery Center where the Surgery is to be performed; and

- Tests are not repeated in or by the Hospital or Surgery Center where the Surgery is done.

If the Participant cancels the scheduled Surgery, Charges are paid as shown under "All Other Covered Medical Expenses" in Plan Features section of this booklet.

Outpatient Surgical Expenses

Charges made by a Surgery Center for Outpatient services and supplies furnished in connection with a surgical procedure performed in the center. The procedure must meet these criteria:

- It is not expected to result in extensive blood loss, require major or prolonged invasion of a body cavity or involve any major blood vessels; and
- It can safely and adequately be performed only in a Surgery Center and it is not normally performed in the office of a Physician or a dentist.

Outpatient Services and Supplies

Outpatient services and supplies are services and supplies furnished by the Surgery Center on the day of the procedure.

Maternity Services - Coverage Related to the Newborn's and Mother's Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict coverage for any Hospital length or stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider (e.g., Physician, nurse midwife or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of coverage or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other healthcare Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). For information on coverage related to the Newborn's and Mother's Health Protection Act, contact your Claims Administrator.

Mental Disorders

Covered Medical Expenses for the treatment of a Mental Disorder are as follows:

- These expenses are covered in the same way as those for any other disease.

Other Covered Medical Expenses include:

- Inpatient treatment, including treatment in a Residential Treatment Facility;
- Outpatient treatment, including partial Hospitalization and intensive Outpatient services;
- Individual and group psychotherapy;
- Counseling with Participants to assist with diagnosis and treatment. This coverage will provide payment for covered services only for Participants covered under this Plan. Charges will be applied to the Participant who is receiving family counseling services, not necessarily to the patient;
- Psychological testing;
- Electroshock therapy and related anesthesia;
- Services to determine if the mental disorder can be treated;
- Services Necessary to evaluate or diagnose mental deficiency or retardation; and
- Services for the treatment of attention deficit disorder.

The course of treatment your Physician or other Covered Provider recommends must be acceptable to Medical Mutual. Inpatient care must be approved by Medical Mutual prior to admission.

Mouth, Jaws and Teeth

Covered Medical Expenses related to treatment of the mouth, jaws and teeth include:

Surgery needed to:

- Treat a fracture, dislocation or wound;
- Cut out:
 - Teeth partly or completely impacted in the bone of the jaw;
 - Teeth that will not erupt through the gum;
 - Other teeth that cannot be removed without cutting into bone;
 - The roots of a tooth without removing the entire tooth; or
 - Cysts, tumors or other diseased tissues.
- Cut into gums and tissues of the mouth when not done in connection with the removal, replacement or repair of teeth; or
- Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Covered Medical Expenses also include nonsurgical treatment of infections or diseases. This does not include those of or related to the teeth.

Dental work, Surgery and orthodontic treatment needed to remove, repair, replace, restore or reposition natural teeth damaged, lost or removed, or other body tissues of the mouth fractured or cut due to injury. Any such teeth must have been free from decay or in good repair and firmly attached to the jawbone at the time of injury.

The treatment must be done in the Benefit Period of the accident or the next Benefit Period.

If crowns (caps), dentures (false teeth), bridgework or in-mouth appliances are installed due to such injury, Covered Medical Expenses include only Charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

The following Charges are Covered Medical Expenses, only if provided in association with injury:

- In-mouth appliances, crowns, bridgework, dentures, tooth restorations or any related fitting or adjustment services whether or not the purpose of such services or supplies is to relieve pain;
- Root canal therapy; and
- Tooth removal (not needing cutting of bone).

Other Covered Medical Expenses

Other Covered Medical Expenses include:

- Charges made by a Hospital for Outpatient services and supplies.
- Charges made by a Physician.
- Injectable prescription drugs approved by the Food and Drug Administration (FDA) for administration by a Covered Provider. In certain circumstances, not all Covered Providers may be able to administer injectable medications.
- Administration by a Covered Provider of FDA approved drugs for self-administration is covered when Necessary.

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

- Charges made for diagnostic X-ray and laboratory tests that reveal need for treatment or are made because of definite symptoms of Condition and X-ray therapy. A diagnostic service is a test or procedure performed when you have specific symptoms to detect or monitor your Condition. It must be ordered by a Physician or Covered Provider and must be Necessary. Covered diagnostic services are limited to the following:

- Radiology, ultrasound and nuclear medicine;
 - Laboratory and pathology services;
 - EKG, EEG, MRI and other electronic diagnostic medical procedures.
- Charges for the rental, purchase, repair or replacement of Durable Medical Equipment, anesthetics and oxygen. The initial purchase of such equipment and accessories needed to operate it is covered only if Medical Mutual is shown that:
 - Long-term use is planned; and
 - The equipment cannot be rented; or
 - It is likely to cost less to purchase it than to rent it.
 Repair or replacement of such purchased equipment and accessories will be covered only if Medical Mutual is shown that it is:
 - Needed due to a change in the Participant's physical Condition; or
 - Likely to cost less to purchase a replacement than to repair the existing equipment or to rent similar equipment.
- Orthotic devices - Rigid or semirigid supportive devices that limit or stop the motion of a weak or diseased body part are covered. These devices include:
 - Back and special surgical corsets;
 - Braces for the leg, arm, neck or back;
 - Therapeutic shoes for select Conditions; and
 - Trusses.
 - Contact lenses or eyeglasses required because of, and prescribed and purchased within one year after cataract Surgery. Coverage will be provided for one pair of contact lenses and one pair of eyeglasses, if both must be worn at the same time.
 - Prosthetic limbs and eyes.
 - Diabetic education that is designed to educate a Participant about the Condition and lifestyle changes Necessary as a result of diabetes. To be considered Covered Medical Expenses, the services must be prescribed by a Physician and furnished by a Covered Provider.
 - Disposable medical and surgical supplies that serve a specific therapeutic purpose. These include oxygen, surgical dressings, Jobst and elastic stockings and other similar items. Items usually stocked in the home for general use such as elastic bandages, thermometers, and corn and bunion pads are not covered.
 - Medical Nutritional Counseling - For Participants provided by a licensed registered dietician.
 - Participant diagnosed with Diabetes - unlimited medical nutritional counseling without a Copayment, Deductible or Coinsurance
 - Other Medical Nutritional Counseling - unlimited visits with a licensed registered dietician, some services received from a Primary Care Provider may not be subject to a Copayment, Deductible or Coinsurance if certain criteria are met.
 - Surgery Necessary due to morbid obesity as defined by Medical Mutual, subject to certain criteria for medical necessity.
 - Wigs or hairpieces when prescribed by a Physician for hair loss due to cancer treatment.

Women's Health and Cancer Rights Act of 1998

In accordance with the Women's Health and Cancer Rights Act of 1998, this Plan will provide coverage to include the following mastectomy-related procedures:

- Reconstruction of the breast on which a mastectomy was performed;
- Reconstructive Surgery of the other breast to present a symmetrical appearance; and
- Prostheses and coverage for physical complications at all stages of a mastectomy procedure, including lymphedemas. This coverage will be provided in consultation with the attending Physician and the patient, and will be subject to the same annual Deductibles and Coinsurance provisions that apply for the mastectomy. If you have any questions about coverage for mastectomies and reconstructive Surgery, please contact Medical Mutual.

Outpatient Rehabilitative and Habilitative Services

Outpatient therapy services must be used to promote recovery from a Condition and ordered by a Physician or other Covered Provider to be covered. Covered Medical Expenses are limited to Necessary therapy services listed below:

- **Cardiac Rehabilitation Services** - Coverage is provided for cardiac rehabilitation services that are Necessary as the result of a cardiac event. The therapy must be reasonably expected to result in a significant improvement in the level of cardiac functioning. Some phases of cardiac rehabilitation services may not be covered.
- **Chemotherapy** - The treatment of malignant disease by chemical or biological antineoplastic agents.
- **Chiropractic Visits** - The treatment given by a chiropractor to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. These covered services include, but are not limited to, office visits, physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices.
- **Dialysis Treatments** - The treatment of an acute or chronic kidney ailment by dialysis methods, including chronic ambulatory peritoneal dialysis that may include the supportive use of an artificial kidney machine.
- **Occupational Therapy** - Occupational therapy services are covered if it is expected that therapy will result in a significant improvement in the level of functioning and that improvement will occur. All occupational therapy services must be performed by a certified, licensed occupational therapist or physical therapist.
- **Physical Therapy** - The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. Covered Medical Expenses include physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices. Services must be provided by a Physician or certified licensed physical therapist.
- **Pulmonary Rehabilitation Services** - Coverage is provided for Physician-supervised outpatient pulmonary therapy provided by a Hospital or other licensed healthcare facility that is Necessary and expected to result in significant improvement of body function.
- **Radiation Therapy** - Treatment of disease by X-ray, radium or radioactive isotopes.
- **Respiratory Therapy** - Treatment by the introduction of dry or moist gases into the lungs.
- **Speech Therapy** - To be considered a Covered Medical Expense this therapy must be performed by a certified, licensed speech therapist and be expected to restore speech for a Participant who has lost existing speech function.

Plastic, Reconstructive or Cosmetic Surgery

Charges for plastic, reconstructive or cosmetic Surgery or other services and supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons, are Covered Medical Expenses provided that the Surgery, services or supplies:

- Improve the function of a part of the body (excluding a tooth or structure that supports the teeth) that is malformed as a result of a severe birth defect. This includes cleft lip or webbed fingers or toes. This also includes body parts malformed as a direct result of a Condition or Surgery performed to treat a Condition.

Prescription Drug Expenses

Prescription Drugs not otherwise listed as covered are available to Participants under a separate prescription drug plan. The OPERS Prescription Drug Program includes both retail pharmacy and mail service pharmacy coverage. Contact OPERS toll-free at 1-800-222-7377 for more information.

Preventive Health Care Services

Charges made by a Physician for a preventive physical exam given to you or your Eligible Dependents may be included as Covered Medical Expenses. A preventive physical exam is a medical exam given by a Physician for a reason other than to diagnose or treat a suspected or identified Condition. This coverage may include a medical history, physical exam,

X-rays, immunizations, lab work and other tests given in connection with the annual exam. The Provider must use a wellness diagnosis code or procedure code to be covered as a preventive service. If a wellness diagnosis code or procedure code is not used, the preventive service will be subject to the Plan's Deductible and Coinsurance.

Covered Preventive Health Services may be subject to frequency, age and gender limitations based on United States Preventive Services Task Force (USPSTF) and Centers for Disease Control (CDC) guidelines and may include:

Preventive Health Care Services -

- Bone Density Testing
- Colonoscopy
- Sigmoidoscopy
- Fecal Occult Blood Test
- Mammogram
- Pap Test
- Physical Examination

Immunizations -

- Diphtheria/Tetanus Toxoids (DT)
- Hepatitis B
- Shingles Vaccine
- Human Papillomavirus Vaccine (HPV)
- Influenza (Flu Vaccine)
- Measles-Mumps-Rubella Vaccine (MMR)
- Meningococcal Vaccine
- Pneumococcal
- Pneumococcal Polysaccharide
- Varicella (Chicken Pox)

Covered Preventive Health Services are subject to frequency, age and gender limitations based on United States Preventive Services Task Force (USPSTF) and Centers for Disease Control (CDC) guidelines.

Well Child Care Services - Coverage for well child care services will be provided for Participants under the age of 21. Coverage for immunizations is also provided for Participants under the age of 21.

Well child care services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination, newborn hearing screening and developmental assessment. Vision tests, hearing tests and the developmental assessment must be included as part of the physical examination in order to be provided as part of this benefit. This review also includes anticipatory guidance, laboratory tests and appropriate immunizations.

Women's Preventive Services - These services will be provided in accordance with the age and frequency requirements of the Affordable Care Act, including, but not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; and counseling for contraceptive methods, breastfeeding and domestic violence.

Coverage is provided for FDA-approved contraceptive methods and counseling.

Additional Preventive Services

If not shown above as a covered service, the following services will also be covered without regard to any Deductible, Copay or Coinsurance requirement that would otherwise apply:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force at the start of the benefit period;
- Immunizations for preventive use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Participant involved;

- With respect to Participants who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration;

Please refer to the phone number on the back of your medical identification 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:

<https://www.uspreventiveservicestaskforce.org/Page/Name/USPSTF-a-and-b-recommendations/>.

For preventive vaccines visit:

www.cdc.gov/vaccines/recs/schedules/default.htm.

Skilled Nursing Facility Expenses

Charges made by a Skilled Nursing Facility for the following services and supplies are covered, but only if furnished to a Participant who requires Skilled Nursing Care in connection with a Condition and only if the services or supplies are Necessary to allow the patient to achieve independence in activities of daily living and to facilitate discharge from the facility:

- Board and Room (this includes Charges for services, such as general nursing care, made in connection with room occupancy);
- Use of special treatment rooms;
- X-ray and lab work;
- Physical, occupational or speech therapy;
- Oxygen and other gas therapy;
- Skilled Nursing Care by an R.N., or by an L.P.N. directed by a full-time R.N., which requires the education, training and technical skills of an R.N. or L.P.N.;
- Other medical services usually given by a Skilled Nursing Facility; and
- Medical supplies not listed above.

Your Physician must order, and Medical Mutual must certify, that you are receiving Skilled Nursing Care and not Custodial Care.

Tobacco Cessation Services

For Participants age 18 and over, coverage is provided for the screening of tobacco use and for tobacco cessation programs for those Participants using tobacco.

Surgical Services

Coverage is provided for Necessary Surgery, and the following specified services:

- Surgery to correct deformity caused by disease, trauma, birth defects, growth defects or prior therapeutic processes; and
- Surgery to improve a functional deficiency.

Diagnostic Surgical Procedures

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

Mastectomy

Your Physician must certify that service is Necessary. Coverage will include reconstruction, prostheses and Surgery to produce symmetrical appearance.

Multiple Surgical Procedures

When two or more Surgeries are performed through the same body opening during one operation, you are covered only for the most complex procedure. The other procedures are considered incidental and not covered. However, if each Surgery is mutually exclusive of the other or is the result of multiple trauma, you will be covered for each Surgery.

When two or more Surgeries are performed through different body openings at the same time, the primary procedure will be covered at the Allowed Amount or Non-Contracting Amount. Subsequent procedures will be covered at half of the Allowed Amount. No coverage will be provided for procedures considered by Medical Mutual to be incidental.

If the Surgery is performed by a Contracting Provider, you will not be responsible for the reduced amount not paid by the Plan. If a Non-Contracting Provider performs Surgery, you may be responsible for the amount not covered by the Plan.

If two or more foot Surgeries (podiatric surgical procedures) are performed, the most complex procedure will be covered at the Allowed Amount. The next two most complex procedures will be covered at half of the Allowed Amount. Subsequent procedures will be covered at one-fourth of the Allowed Amount. If Surgery is performed by a Non-Contracting Provider, you may be responsible for the amounts not covered by the Plan.

Bilateral Surgical Procedures

When the same surgical procedure is performed bilaterally (i.e., on two sides) during one operative setting, one side will be covered at the Allowed Amount and the subsequent side will be covered at half of the Allowed Amount for the particular procedure. If Surgery is performed by a Contracting Provider, you will not be responsible for the reduced amount not paid by the Plan. If the Surgery is performed by a Non-Contracting Provider, you may be responsible for the amount not covered by the Plan.

Assistant at Surgery

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

Anesthesia

Your coverage includes the administration of anesthesia performed in connection with a Covered Medical Expense by a Physician, Covered Provider, Certified Registered Nurse Anesthetist who is not the surgeon or the assistant at Surgery, or by the surgeon in connection with covered oral surgical procedures. The services of a stand-by anesthesiologist are only covered during coronary angioplasty Surgery. This coverage includes care before and after the administration of anesthesia.

Transplant Services

Your coverage includes coverage for the following human transplants:

- Bone marrow transplant;
- Cornea;
- Heart;
- Heart and lung;
- Kidney;
- Liver;
- Lung;
- Pancreas;
- Pancreas/Kidney;
- Blood components (Cord blood and stem cell); and
- Tissue.

Obtaining Donor Organs or Tissue

The following services will be Covered Medical Expenses when they are Necessary to acquire a legally obtained human organ or tissue:

- Evaluation of the organ or tissue;
- Removal of the organ or tissue from the donor; and
- Transportation of the organ or tissue to the Transplant Center.

Donor Coverage

Coverage Necessary for obtaining an organ or tissue from a living donor or cadaver is provided. Donor coverage is provided and processed only under the transplant recipient's coverage and are subject to any applicable limitations and exclusions.

Transportation and Lodging

Transportation and lodging services are only covered if the Participant lives more than 100 miles from the transplant facility. The following coverage and guidelines apply:

- Transportation is to and from the Hospital where the transplant is performed.
- Temporary lodging at a prearranged location when requested by the Hospital. Coverage is also provided for one support person, or two persons if the recipient is under age 18.

Coverage is limited to the amount specified in the Plan Features section of this booklet.

EXCLUSIONS

In addition to the exclusions and limitations explained in the Comprehensive Medical Expense section as determined by Medical Mutual, coverage is not provided for services and supplies listed. In addition, the law of an area where a Participant lives may not allow coverage to be paid for certain expenses.

1. For elective abortions. Abortions performed when the mother's life is endangered by continuation of the pregnancy will be covered.
2. For which you have no legal obligation to pay in the absence of this or like coverage.
3. For acupuncture.
4. For ambulette services
5. For topical anesthetics or stand-by anesthesia, except as specified.
6. For biliary lithotripsy.
7. For the treatment of infertility, including, but not limited to, artificial insemination, in vitro fertilization, Gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT).
8. For treatment of Conditions related to Autism Spectrum Disorders, learning disabilities, hyperkinetic syndromes, behavioral problems or intellectual disability, except as specified.
9. For arch supports and other foot care or foot support devices used only to improve comfort or appearance. These include but are not limited to: Devices to care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses and toenails.
10. For blood that is available without charge and for blood storage services provided by other than a Hospital.
11. For braces and molds for outpatient therapy services administered for chiropractic care or physical therapy, except as required under PPACA.
12. For chemonucleolysis.
13. For specialized camps.
14. For Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form.
15. Charges that are not Necessary, as determined by Medical Mutual.
16. For counseling services, including marriage, family, career, social adjustment, pastoral and financial.
17. For over the counter drugs, vitamins or herbal remedies, except for certain preventive drugs written with a Physician's prescription and required by PPACA.
18. For prescription drugs, except as specified.
19. For educational, vocational or training purposes, except as specified or required by PPACA.
20. 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.
21. For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability or similar laws, even when the Participant does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a Participant who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.
22. For Experimental or Investigation equipment, drugs, devices, services, supplies, tests, medical treatments or procedures unless otherwise specified in this Medical Plan Description.
23. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except those for aphakic patients and soft lenses or sclera shells for use as corneal bandages or when needed as a result of keratoconus Surgery.
24. Received from a member of your Immediate Family.
25. For fraudulent or misrepresented claims.
26. To the extent those governmental units or their agencies provide coverage.
27. For hearing aids, examinations or fittings, unless otherwise noted in this document.
28. For home uterine activity monitoring.
29. For human growth hormone therapy.

30. For hyperhidrosis.
31. For hypnosis.
32. For treatment with intraoral prosthetic devices, or by any other method, to alter vertical dimension.
33. For which benefits are payable under Medicare Parts A, B and/or D or would have been payable if a Participant had applied for Parts A, B and/or D, except, as specified elsewhere in this Medical Plan Description or as otherwise prohibited by federal law.
34. Received in a military facility for a Condition related to military service past or present.
35. For treatments associated with mouth, jaws, or teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For non-covered services or services specifically excluded in the text of this Medical Plan Description.
37. For the first Inpatient visit to examine a newborn and any nursery care rendered, except as specified.
38. For oral implants considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic except when due to trauma, accident or as deemed Necessary by Medical Mutual.
39. For personal hygiene and convenience items.
40. Physical examination or services required by an employer to begin or continue working.
41. Physical examination or services required by a governmental agency such as the FAA and DOT.
42. Physical examination or services required by an insurance company to obtain insurance.
43. Premarital examinations.
44. For private duty nursing services.
45. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
46. Received from other than a Provider.
47. Not performed within the scope of the Provider's license.
48. Screening examinations, except as specified.
49. For the medical treatment of sexual problems not caused by a biological Condition.
50. For reverse sterilization.
51. For male contraceptives and over-the-counter birth control without a prescription.
52. For any Charges Incurred as a result of any Participant acting as or contracting to be a surrogate parent.
53. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
54. Incurred after you are no longer a Participant except as specified in the Coverage After Termination section.
55. Therapy or rehabilitation as follows:
 - bioenergetic therapy;
 - carbon dioxide therapy;
 - massotherapy or massage therapy;
 - megavitamin therapy;
 - primal therapy;
 - psychodrama;
 - rolfing;
 - sensory integration therapy;
 - vision perception training (including orthoptic training); and
 - water aerobics
56. For treatment of the vertebral column unless related to a specific, neuromusculoskeletal related diagnosis.
57. For any surgical procedure for the correction of a visual refraction problem, including, but not limited to, radial keratotomy and LASIK Surgery.
58. For a Condition that occurs as a result of any act of war.
59. For treatment, by methods such as dietary supplements, vitamins and other care, that is primarily dieting or exercise for weight loss.

IMPORTANT PLAN PROVISIONS

Medicare Secondary Plan

Under the Medicare Secondary Plan you may use any Provider to receive coverage up to the Allowed Amounts.

Adjustment Rule

If, for any reason, a Participant is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the Plan document on file with OPERS.

Coverage for claims Incurred after the date the adjustment becomes effective are payable in accordance with the revised Plan provisions. In other words, there are not vested rights to coverage based upon provisions of this Plan in effect prior to the date of any adjustment.

Assignment

Medical Mutual will pay directly to the Provider rendering services. Coverage payments for Contracting Providers are paid directly to the Provider rendering service. You cannot assign your right to receive payment to a Non-Contracting Provider.

Coverage Payment

Coverage will be paid as soon as the necessary written proof to support the claim is received. Most Providers will submit a claim for you. If you submit a claim yourself, use a claim form. In most cases, you can obtain a claim form from Medical Mutual or a Provider. Medical Mutual must receive a completed claim form with the correct information. If you need assistance completing your claim form, contact Medical Mutual. Medical Mutual may require nurse's notes or other medical records before proof of loss is considered sufficient to determine coverage.

The Plan is not legally obligated to reimburse for Covered Medical Expenses unless written or electronically submitted proof that Covered Medical Expenses have been given to you is received.

To have a payment or denial related to a claim reviewed, you must send a written request to Medical Mutual within six months of the claim determination. No claim can be submitted later than two years after services have been received.

Payment for Emergency Services

Your Plan will not require prior authorization or impose any other administrative requirements or coverage limitations that are more restrictive if you receive Emergency Services from a Non-Contracting Provider. **However, a Non-Contracting 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 better coverage, your Plan will apply the same Copayments and Coinsurance for Emergency Services from a Non-Contracting Provider as it generally requires for Emergency Services received from a Contracting Provider. A Deductible may be imposed for Non-Contracting Emergency Services, only as part of the Deductible that generally applies to Non-Contracting coverage. Similarly, any Out-of-Pocket that generally applies to Non-Contracting coverage will apply to Emergency Services received from a Non-Contracting Provider.

Medical Mutual pays for covered services through agreements with Contracting Providers based on the Allowed Amount. For Non-Contracting Providers, Medical Mutual pays for coverage based on the Non-Contracting Amount.

Your Financial Responsibilities

The Plan Features section shows your and the Plan's financial responsibility for Covered Medical Expenses. The Deductible, Coinsurance Maximums and Maximum Out-of-Pockets renew at the beginning of every Benefit Period. After Medical Mutual, as the claims administrator, has paid the amounts, on behalf of the Plan, indicated in the Plan Features section, you assume the remaining liability for Covered Medical Expenses. Deductibles, Coinsurance and amounts paid by other parties do not accumulate toward Maximum Out-of-Pocket amounts.

In addition to Deductible and Coinsurance amounts, you are responsible for paying Non-Covered Charges, Excess Charges and Billed Charges for all services and supplies after coverage maximums have been reached.

Medical Mutual, as the claims administrator, pays claims on behalf of the Plan, for Covered Medical Expenses through agreements with Contracting Providers based on preset reimbursement amounts. For Covered Medical Expenses rendered by Contracting Providers, Medical Mutual will calculate your Deductible, Coinsurance, Coinsurance and Maximum Out-of-Pockets accumulation based on the Allowed Amount. When Covered Medical Expenses are rendered, these Covered Providers have agreed not to bill for any amount of Covered Medical Expenses above the Negotiated Amount, except for services and supplies for which the Plan has no financial responsibility because of a coverage maximum.

For Covered Medical Expenses rendered by Non-Contracting Providers, Medical Mutual will calculate your Deductible, Coinsurance accumulations based on the Non-Contracting Amount. You may be responsible for Excess Charges up to the amount of the Provider's Billed Charges. Any Excess Charges billed by Non-Contracting Providers DO NOT apply to the Coinsurance Maximum.

Annual Deductible

Every Benefit Period, you must pay the dollar amount specified as the Deductible in the Plan Features section before the Plan will provide coverage. The Deductible is the amount each Participant must pay before the Plan will provide coverage for Covered Medical Expenses. If a Charge is subject to a Deductible, only Covered Medical Expenses under that coverage will satisfy the Deductible. Certain out-of-pocket expenses do not accumulate toward the annual Deductible. These include expenses Incurred from office visit Copays, and Copays associated with emergency room services or Urgent Care. In addition, Inpatient Deductible amounts do not accrue toward the annual Deductible. To satisfy your Deductible, the Plan records must show that you have Incurred claims totaling the specified dollar amount. For this reason, it is important for you to submit copies of all your bills for Covered Medical Expenses. 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.

Coinsurance Maximum

When the amount a Participant must pay in Coinsurance for Covered Medical Expenses reaches the total listed in the Plan Features section, coverage will be payable at 100 percent for all Covered Medical Expenses to which this limit applies for the rest of that Benefit Period. **You will still be responsible for any applicable Copayments.**

The amounts you pay toward your annual Deductible do not count toward the Coinsurance Maximum. Amounts you pay for Excess Charges do not apply to any Coinsurance Maximum.

Maximum Out-of-Pocket

After the applicable Maximum Out-of-Pocket shown in the Plan Features section has been met, you are no longer responsible for paying any further Copayments, Deductibles or Coinsurance for Covered Medical Expenses Incurred during the balance of the Benefit Period. Any charges Incurred in excess of a coverage maximum do not count toward the Maximum Out-of-Pocket. Amounts you pay for Excess Charges do not apply to the Maximum Out-of-Pocket.

Lifetime Coverage

This is the highest amount that will be paid under this Plan for any Participant during his or her lifetime. The Lifetime Coverage is unlimited. The Essential Health Benefits that are provided by your Plan are not subject to a lifetime dollar limit.

Changes in Coverage or Provisions

From time to time Medical Mutual may revise its coverage guidelines and those revisions may alter the nature of Covered Medical Expenses. It is the responsibility of OPERS to notify you when these changes go into effect. If you or an Eligible Dependent are undergoing a course of treatment considered covered under previous guidelines, Medical Mutual will apply the guidelines only if the course of treatment continues to be a covered service under the revised coverage.

Foreign Travel

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

To receive reimbursement for Hospital and/or medical expenses, the services rendered must be eligible for coverage in accordance with the benefits described in this booklet..

Monthly Premiums

You will be responsible for paying part of the cost of health care coverage through a monthly premium withheld from your OPERS benefit, direct payment to OPERS, or a combination of these methods. Monthly premiums differ depending on your years of OPERS service credit, your age at enrollment, your enrolled Eligible Dependents and re-employment with an OPERS-covered employer. The OPERS Board determines monthly premiums and may change the premiums periodically. For more information about monthly premiums, contact OPERS.

Coordination of Coverage

The Coordination of Benefits ("COB") provision applies when a Participant has health care coverage under more than one plan. Plan is defined below for COB purposes only.

The order of coverage determination rules govern the order in which each plan will pay a claim for coverage. The plan that pays first is called the Primary plan. The Primary plan must pay for services 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 coverage it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Definitions

1. A plan is any of the following that provides coverage 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 coverage to which the COB provision applies and which may be reduced because of the coverage of other plans. Any other part of the contract providing health care coverage is separate from this plan. A contract may apply one COB provision to certain services, such as dental services, coordinating only with similar services, and may apply another COB provision to coordinate other coverage.
3. The order of coverage determination rules determine whether this Plan is a Primary plan or Secondary plan when the Participant has health care coverage under more than one plan.

When this Plan is primary, it determines payment for its coverage first before those of any other plan without considering any other plan's coverage. When this Plan is secondary, it determines its coverage after those of another plan and may reduce the coverage it pays so that all Plan services do not exceed 100% of the total allowable expense.

4. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copays, that is covered at least in part by any plan covering the person. When a plan provides coverage 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 Participant 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 Participant 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 Participant 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 Participant 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 Participant 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 coverage 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 Coverage Determination Rules

When a Participant is covered by two or more plans, the rules for determining the order of coverage payments are as follows:

1. The Primary plan pays or provides its services according to its terms of coverage and without regard to the coverage 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 services 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 coverage using the first of the following rules that apply:
 - a. Non-Dependent or Dependent. The plan that covers the Participant other than as a dependent, for example as an employee, participant, policyholder, subscriber or retiree, is the Primary plan and the plan that covers the Participant 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 Participant as other than a dependent (e.g. a retired employee), then the order of coverage between the two plans is reversed so that the plan covering the Participant as an employee, participant, 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 coverage 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 coverage;
 - 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 coverage; 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 coverage 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 coverage as if those individuals were the parents of the child.
 - c. Active employee or retired or laid-off employee. The plan that covers a Participant as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The plan covering that same Participant as a retired or laid-off employee is the Secondary plan. The same would hold true if a Participant is a dependent of an active employee and that same Participant 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 coverage, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of coverage.
 - d. COBRA or state continuation coverage. If a Participant 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 Participant as an employee, participant, subscriber or retiree or covering the Participant as a dependent of an employee, participant, 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 coverage.

- e. Longer or shorter length of coverage. The plan that covered the Participant as an employee, participant, policyholder, subscriber or retiree longer is the Primary plan and the plan that covered the Participant the shorter period of time is the Secondary plan.
- f. If the preceding rules do not determine the order of coverage, 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 Coverage Of This Plan

1. When this Plan is secondary, it may reduce its coverage so that the total services 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 coverage 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 services 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 Participant 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 coverage 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 services payable under this Plan and other plans covering the Participant claiming coverage. Medical Mutual need not tell, or get the consent of, any Participant to do this. Each Participant claiming coverage under this Plan must give Medical Mutual any facts it needs to apply those rules and determine services 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 coverage 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 Participant it has paid or for whom it has paid, or any other person or organization that may be responsible for the services provided for the Participant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should attempt to resolve the problem by contacting Customer Care at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or medical identification card.

If you or your Eligible Dependent is covered by a Medicare-contracted HMO on either an individual or group basis and elects to receive services that are not authorized by the HMO or that are Out-of-Network services, OPERS coverage for such will be computed after estimated Medicare payments are taken into consideration.

Provision Enforcement

Medical Mutual will be responsible for obtaining information relating to coordination of coverage for you and your Eligible Dependents and coordinating coverage according to the requirements of Ohio and Federal law.

To apply and enforce this provision or any similar provision of another health care Plan, it is agreed that:

- Any Participant claiming coverage described in this *Medical Plan Description* will furnish Medical Mutual with any information Medical Mutual needs; and
- Medical Mutual may, without the consent of or notice to any Participant, release to or obtain from any source any necessary information.

Returning to Work After Retirement

Re-employment is returning to work in an OPERS-covered position after retiring. Employers must provide health care coverage for OPERS age and service retirees who are re-employed in an OPERS-covered position if the coverage is available to other employees in comparable positions.

The employer's health care coverage is primary and, if the retiree is participating in the OPERS health care program, OPERS coverage is secondary for the duration of re-employment. **The re-employed retiree may not waive the employer's health care coverage.**

OPERS' health care coverage is not provided during a retiree's suspension or forfeiture of a retirement benefit as a result of re-employment.

Effect of Medicare

This section describes how medical expense coverage under this Plan varies depending on whether the Participant is eligible for Medicare. The month you or your spouse are enrolled in Medicare Parts A and B, you will have the option to enroll in an individual Medicare plan through OPERS' Medicare Connector, administered by Via Benefits.

Medicare Part A (hospitalization)

Medicare Part A, known as Hospital insurance, helps cover Inpatient care in Hospitals and Skilled Nursing Facilities. It also covers Hospice Care and some Home Health Care. A Participant is automatically eligible for coverage under Medicare Part A at age 65 if he or she is eligible to receive Social Security or railroad retirement coverage. In addition, there are other circumstances in which a Participant can become eligible for Medicare Part A either before or after age 65.

Medicare Part B (medical)

Medicare Part B, also known as medical insurance, helps cover medically Necessary physicians services, outpatient Hospital care and some other medical services that Medicare Part A does not cover, such as some of the services of physical and occupational therapists and some Home Health Care. A Participant must enroll in Medicare Part B to receive coverage.

Plan Changes Relating to Medicare Parts A and B

The following are changes in medical expense coverage when Medicare is involved:

- All medical expenses covered under this Plan will be reduced by any Medicare coverage available for those expenses. This will be done before the medical coverage of this Plan is figured;
- Charges used to satisfy a Participant's Part B Deductible under Medicare will be applied under this Plan in the order received by Medical Mutual. Two or more Charges received at the same time will be applied starting with the largest first; and
- Any rule for coordinating other plan coverage with those under this Plan will be applied after this Plan's coverage has been figured under the above rules. Allowable expenses will be reduced by any Medicare coverage available for those expenses.

Early Medicare

Early Medicare occurs when a Participant becomes eligible for Medicare due to a Social Security Administration (SSA) disability benefit or due to end stage renal disease (ESRD) prior to reaching age eligibility for Medicare. If the Participant has Medicare due to ESRD, the Plan will pay before Medicare for a period of 30 months. The Plan will pay after Medicare once the initial 30 month period has expired.

Subrogation/Right of Recovery of Expenses Paid

Definitions

For purposes of this section, the following terms are used:

Insurance Coverage - Any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first-party insurance coverage.

Responsible Party - Any party actually, possibly or potentially responsible for making any payment to a Participant due to a Participant's injury, illness or Condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

Subrogation

Immediately upon paying or providing any coverage under this Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Participant has against any Responsible Party with respect to any payment made by the Responsible Party to a Participant due to a Participant's injury, illness or Condition to the full extent of coverage provided or to be provided by the Plan.

Reimbursement

In addition, if a Participant receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness or Condition, the Plan has the right to recover from, and be reimbursed by, the Participant for all amounts this Plan has paid and will pay as a result of that injury, illness or Condition, up to and including the full amount the Participant receives from any Responsible Party.

Constructive Trust

By accepting coverage (whether the payment of such coverage is made to the Participant or made on behalf of the Participant to any provider) from the Plan, the Participant agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness or Condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Participant's fiduciary duty to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of coverage paid by the Plan for the treatment of the illness, injury or Condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise related to treatment for any illness, injury or Condition for which the Plan paid coverage. The lien may be enforced against any party who possesses funds or proceeds representing the amount of coverage paid by the Plan including, but not limited to, the Participant, the Participant's representative or agent; Responsible Party; Responsible Party's insurer, representative or agent; and/or any other source possessing funds representing the amount of coverage paid by the Plan.

First-Priority Claim

By accepting payment (whether the payment is made to the Participant or made on behalf of the Participant to any provider) from the Plan, the Participant acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Participant's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Participant which is insufficient to make the Participant whole or to compensate the Participant in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Participant to pursue the Participant's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Participant identifies the medical coverage the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled

to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Participant shall fully cooperate with the Plan's efforts to recover its Charges paid. It is the duty of the Participant to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Participant's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or Condition sustained by the Participant. The Participant and his or her agents shall provide all information requested by the Plan, Medical Mutual or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health coverage for the Participant or the institution of court proceedings against the Participant.

The Participant shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all coverage provided by the Plan.

The Participant acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or Condition to identify any Responsible Party. The Plan reserves the right to notify the responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

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

Jurisdiction

By accepting coverage (whether the payment is made to the Participant or made on behalf of the Participant to any provider) from the Plan, the Participant agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such payment, the Participant hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Exclusion

This Plan does not cover services and supplies, in the opinion of Medical Mutual or its authorized representative, that are associated with injuries, illness or Conditions suffered due to the acts or omissions of a third party.

Severability

If any one or more of the clauses contained in this "Subrogation and Right of Recovery Provision" is held to be invalid, illegal or unenforceable by any court of competent jurisdiction in any respect under any applicable law, the validity, legality and enforceability of the remaining provisions contained in this Subrogation and Right of Recovery Provision shall not in any way be affected or impaired. In the case of any determination of illegality, invalidity or unenforceability, the invalid, illegal or unenforceable clause shall be deemed enforceable to the fullest extent permitted by law and the parties shall use their best efforts to substitute a valid clause for the invalid clause.

Recovery of Overpayment

If a payment is made by Medical Mutual, to or on behalf of any Participant, which exceeds the coverage amount such Participant is entitled to receive in accordance with the terms of the Contract, this Plan has the right to:

- Require the return of the overpayment on request; or
- Reduce by the amount of the overpayment, any future payment made to or on behalf of that Participant or another Participant in his or her family.

OPERS may be entitled to recover the costs of any claims paid to a Participant if it is determined that the individual was not eligible for coverage at the time the claims were incurred.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

Reporting Claims

A Participant may submit any claim for Medical Care expenses to Medical Mutual if the Provider fails to do so. The claim must be submitted to Medical Mutual in writing and give proof of the nature and extent of the Medical Care involved. Please contact the Claims Administrator for the required forms.

All claims should be reported promptly. No claim can be submitted later than two years after services have been received. The two-year period will not apply if Medical Mutual receives a coordinated claim for secondary coverage outside the two-year period, if the claim was submitted to the primary carrier within two years of the date of service.

Unless you are legally incapacitated, late claims will not be covered if they are filed more than two years after the deadline.

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.

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.

A Participant's coverage shall be rescinded if the Participant is convicted of falsification under Section 2921.13 of the Ohio Revised Code regarding the health care coverage or performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact regarding the health care coverage. The effective date of the termination of coverage shall be the earlier of the date of the conviction or the act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact, unless otherwise limited by Ohio law. OPERS shall notify the Participant of the rescission at least thirty days prior to processing the rescission. The rescission applies to all Participants and all coverage options.

Keeping Records of Expenses

Keep complete records of the expenses of each Participant. They are required when a claim is made.

The names of Physicians and others who furnish services, dates expenses are Incurred and copies of all bills and receipts are very important.

Explanation of Benefits Statements

After Medical Mutual processes your claim, an Explanation of Benefits (EOB) will be mailed to you. These also can be viewed on Medical Mutual's website. They list Covered Medical Expenses and non-covered services along with explanations about why services are not covered. They also contain important information and a telephone number if you have any questions.

Claim Review

Consent to Release Medical Information - Denial of Coverage

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

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

Right to Review Claims

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

Physical Examination

The Plan may require that you have one or more physical examinations at its expense. These examinations will help to determine what services 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 Participant or your eligibility.

Benefit Determination for Claims

Urgent Care Claims

An **Urgent Care Claim** is a claim for Medical 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 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 layperson that possesses an average knowledge of medicine or (b) any Physician with knowledge of the claimant's medical Condition 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 and explain the applicable procedural deficiencies, or the specific deficiencies related to information necessary to make a benefit determination. You will have 48 hours to correct the procedural deficiencies and/or provide the requested information. Once Medical Mutual receives the requested information, we will notify you of the benefit determination as soon as possible, taking into account all medical exigencies, but not later than 48 hours after receipt of the information.

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

Concurrent Care Claims

A Concurrent Care Claim is any claim for ongoing treatment to be provided over a period of time or for a number of treatments, subject to Medical Mutual's approval. The decision is adverse if Medical Mutual decides to reduce or terminate benefits for the ongoing treatment (unless the reduction or termination of benefits is 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 as a condition for payment of a benefit (either in whole or in part).

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 or an Urgent Care 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 30 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 a benefit will be made in a culturally and linguistically appropriate manner and will include the following:

- the specific reason(s) for the denial;
- reference to the specific plan provision(s) on which the denial is based;
- sufficient information to identify the claim involved, including the date of services, the health care provider, and the claim amount, if applicable;
- 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 and applicable timeframes, including the expedited appeal process, if applicable;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the claim was denied based on Medical Necessity, Experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

Filing a Complaint

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

Quality of care issues are addressed by Medical Mutual's 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

* **Please note:** The processes described here are based on the claims and appeals processes set forth in the Patient Protection and Affordable Care Act and related regulations and guidance. As those regulations and guidance are subject to change, the claims and appeals processes for this plan are subject to change. The rules and/or procedures set forth in the most current claims and appeals regulations and guidance at the time your claim or appeal is processed will govern your claims and appeals, even if they conflict with the claims and appeals processes set forth herein.

Filing an Appeal

If you are not satisfied with any of the following:

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

then you may file an appeal.

To submit an appeal electronically, go to Medical Mutual's Web site, www.medmutual.com, under Members' section, complete all required fields and submit, or call the Customer Care telephone number on your identification card. You may also write a letter with the following information: Card Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, documents, dental X-rays or photographs you would like considered in the appeal. Send or fax the letter and records to:

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

The request for review must come directly from the patient unless he/she is a minor or has appointed an authorized representative. You can choose another person to represent you during the appeal process, as long as Medical Mutual has a signed and dated statement from you authorizing the person to act on your behalf.

Mandatory Internal Appeal

The Plan offers you a mandatory internal appeal. You must complete this mandatory internal appeal before any additional action is taken.

Mandatory internal 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 submitting an electronic form, by calling Customer Care or in writing as described in the Filing an Appeal section above.

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law for this plan. The internal appeal process is a review of your appeal by an appeals specialist, a Physician consultant and/or other licensed health care professional. The review of an appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations that involve, in whole or in part, issues of Medical Necessity, whether services are Experimental and Investigational, or any other medical judgment, are based on the evaluations and opinions of 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 evaluations about your claim and will not be a subordinate of the professional who made the initial evaluation of your claim. These health care professionals 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. Upon specific written request from you, Medical Mutual will provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

You may submit written comments, documents, records, testimony and other information relating to the claim that is the basis for the appeal. These documents should be submitted by you at the time you send in your request for an appeal. 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 is the subject of your appeal.

If, during the appeal, Medical Mutual considers, relies upon or generates any new or additional evidence, you will be provided free of charge with copies of that evidence before a notice of denial is issued. You will have an opportunity to respond before our time frame for issuing a notice of denial expires. Additionally, if Medical Mutual decides to issue a final denial based on a new or additional rationale, you will be provided that rationale free of charge before the final notice of denial is issued. You will have an opportunity to respond before our timeframe for issuing a notice of denial expires.

You will receive continued coverage pending the outcome of the appeals process. This means that Medical Mutual may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review.

The appeal procedures are as follows:

Urgent Care Appeal

- You, your authorized representative or your Provider may request an appeal for urgent care. The appeal does not need to be submitted in writing. You, your authorized representative, or your Physician should call the Care Management telephone number on your identification card as soon as possible. Urgent care claim appeals are typically those claims for Medical Care or treatment where withholding immediate treatment (1) could seriously jeopardize the life or health of a patient, or could affect the ability of the patient to regain maximum functions, or (2) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The appeal must be decided within 72 hours of the request. The expedited review process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action. When you request an internal appeal for an urgent care claim, at the same time you may also file a request for an expedited external review as described below.

Pre-Service Claim Appeal

- You or your authorized representative may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a service, as it relates to the terms of the plan benefit booklet. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of denial.

Post Service Claim Appeal

- You or your authorized representative may request a post-service claim appeal. Post-service claim appeals are those requested for payment or reimbursement of the cost for Medical Care that has already been provided. As with pre-service claims, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of the denial.

All appeal denial notices will be culturally and linguistically appropriate and will include the following:

- the specific reason(s) for the denial;
- reference to the specific plan provision(s) on which the denial is based;

- sufficient information to identify the claim involved, including the date of services, the health care provider, and the claim amount (if applicable);
- statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- if the claim was denied based on a Medical Necessity, Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request; and
- a description of applicable appeal procedures.

If your claim is denied at the internal mandatory appeal level, then depending on the type of plan you have and the type of claim, there are two different voluntary review options available. You will be eligible for EITHER the External Review Process OR the Voluntary Internal Review Process. These two processes, and the eligibility requirements, are described below.

External Review Process

Medical Mutual has established an external review process to examine coverage decisions under certain circumstances. The request for External Review must be made within four months from your receipt of the notice of denial from the internal mandatory appeal. You may be eligible to have a decision reviewed through the external review process if you meet the following criteria:

1. The adverse benefit determination involves medical judgment, as determined by the external reviewer, or a rescission of coverage;
2. You have exhausted the mandatory internal appeal process unless under applicable law you are not required to exhaust the internal appeal process;
3. You are or were covered under the plan at the time the service was requested or, in the case of retrospective review, were covered under the plan when the service was provided; and
4. You have provided all of the information and forms necessary to process the external review.

External Review will be conducted by Independent Review Organizations (IRO). You will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review your claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

Medical Mutual is required by law to provide to the independent review organization conducting the review, a copy of the records that are relevant to your medical Condition and the external review.

External Review for Non-Urgent Care Claim Appeals

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to Medical Mutual's Member Appeals Unit at the address listed above.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will notify you and give you 10 business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. This written decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either Plan or you. If the IRO reverses the adverse benefit determination, your Plan will provide coverage or payment for the claim.

Expedited External Review for Urgent Care Claim Appeals

A request for an external review for Urgent or Expedited claims may be requested orally or electronically or in writing and should be addressed to Medical Mutual's Member Appeals Unit. You may request an external review for Urgent or Expedited claims at the same time you request an expedited internal appeal of your claim.

An expedited review may be requested if your Condition, without immediate medical attention, could result in serious jeopardy to your life or health or your ability to regain maximum function; or you have received a final internal appeal denial concerning an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either plan or you. If the IRO reverses the adverse benefit determination, the Plan will provide coverage or payment for the claim.

Voluntary Internal Review Process

If your internal mandatory appeal is denied, and your claim does not qualify for an external review, you have the option of a voluntary internal review by Medical Mutual. All requests for review may be made by calling Customer Care or writing to the Member Appeals Department. You should submit additional written comments, documents, records, dental X-rays, photographs and other information that were not submitted for the internal mandatory appeal.

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

The voluntary internal review provides a full and fair review of the claim. The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the internal mandatory appeal.

Termination of Coverage

Coverage under this Plan terminates at the earliest occurrence of one of the following:

- When coverage under the Plan discontinues;
- When you cease to be a Participant. All coverage stops at the end of the month in which the Participant becomes ineligible; or
- When you fail to pay the premium for coverage.

If your coverage ceases for any reason, contact OPERS immediately to find out what rights you may have under this Plan.

You may terminate coverage under any OPERS-sponsored health care Plan at any time. For instructions, please call OPERS toll-free at 1-800-222-7377.

Eligible Dependent Coverage Only:

An Eligible Dependent's coverage will terminate at the earliest occurrence of one of the following (It is the Participant's responsibility to notify OPERS):

- Discontinuance of all dependent coverage under the Plan;
- When an Eligible Dependent becomes covered as an Eligible Benefit Recipient and chooses OPERS health care coverage under his or her own plan;
- When such Participant ceases to meet this Plan's definition of an Eligible Dependent;
- When Eligible Benefit Recipient coverage terminates;
- When you fail to make a required premium payment; or
- Within 31 days from the day you notify OPERS that coverage of an Eligible Dependent is to terminate.

Continuation of Medical Expense Coverage After Termination

If at the time this Plan discontinues, a Participant is confined in a Hospital, nursing home, Skilled Nursing Facility or institution devoted exclusively to the treatment of alcoholism or drug abuse, coverage will be available for Covered Medical Expenses directly related to such confinement during the first 31 consecutive days following termination of this Plan.

If this Plan discontinues during a pregnancy of a Participant, any coverage provided in connection with such pregnancy will continue to be available, but only during the first 31 consecutive days following termination of this Plan.

If you die while covered under any part of this Plan, any medical expense coverage then in force for your Eligible Dependents may be continued subject to determination of continuing eligibility by OPERS and subject to the ongoing offering of the Plan's continuation of coverage options, which are described in the next section of this booklet.

Any dependent's coverage, including your spouse's, will cease when any one of the following events occur:

- Your spouse dies;
- A dependent ceases to meet the definition of an Eligible Dependent;
- A dependent becomes an Eligible Benefit Recipient under this Plan and elects health care coverage under his or her own plan;
- The Plan terminates coverage for the category under which the dependent qualified as an Eligible Dependent;
- Any required premiums stop; or
- In the case of an incapacitated Participant:
 - Cessation of the incapacitating Condition;
 - Failure to provide proof that the incapacitating Condition continues; or
 - Failure to obtain any required exam.

If medical expense coverage is being continued for your Eligible Dependents, your child born after your death also will be eligible for coverage.

CONTINUATION OF COVERAGE OPTIONS

If your coverage under this Plan ceases for any reason, depending upon your individual circumstances and factors determined by OPERS, you may have options for continuation of coverage. For more information on these options, contact OPERS.

COBRA

Participants are eligible for continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA is a federal law that allows Participants to continue coverage under specified circumstances where such group coverage would otherwise be lost. To continue coverage, the Participant must apply for continuation coverage and pay the required premium before the deadline for payment. COBRA coverage can extend up to 36 months, depending on the particular "qualifying event" which gave rise to COBRA.

Notice Requirements

Under COBRA, the Participant is responsible for informing OPERS of a qualifying event, such as, divorce, legal separation or a child's 26th birthday within 60 days of any such event. If notice is not received within that 60-day period, the Participant will not be entitled to choose continuation coverage.

OPERS Retirement Board

The 11-member OPERS Retirement Board is responsible for the administration and management of OPERS. Seven of the 11 members are elected by the groups that they represent (i.e., college and university non-teaching employees, state, county, municipal, and miscellaneous employees, and retired members); the Director of the Department of Administrative Services for the state of Ohio is a statutory member, and three members are investment experts appointed by the Governor, the Treasurer of State, and jointly by the Speaker of the Ohio House of Representatives and the President of the Ohio Senate.

For a current listing of OPERS Board Members, please visit www.OPERS.org.

Multi-Language Interpreter Services & Nondiscrimination Notice



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

Spanish

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

Chinese

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

German

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

Arabic

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

Pennsylvania Dutch

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

Russian

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

French

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

Vietnamese

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

Navajo

Díí baa akó nínizín: Díí saad bee yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, kójjí' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

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

Korean

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

Italian

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

Japanese

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

Dutch

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

Ukrainian

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

Romanian

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

Tagalog

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

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

Nondiscrimination Notice

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

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

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

Civil Rights Coordinator

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

Email: CivilRightsCoordinator@MedMutual.com

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

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

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

