

CLEVELAND STATE UNIVERSITY

**Group Number
961056-007, 012**

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Dental PPO Network Certificate

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DENTAL PPO NETWORK SCHEDULE OF BENEFITS

Benefit Period	Calendar year
Non-PPO Network Benefit Period Deductible	\$50 single
Maximum benefit per Covered Person per Benefit Period	\$1,200
Dependent Age Limit	The end of the month of the 23rd birthday

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

IMPORTANT - Read This Section

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

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

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

Type of Service	Maximums and Limitations
Oral Evaluations	One per six (6) month period
Bitewing x-rays	One set per six (6) month period
Periodontal Cleaning	One exam per six (6) month period
Prophylaxis	One exam per six (6) month period
Topical Fluoride Applications	One per six (6) month period
Sealants	For Eligible Dependent children under age 14
Space Maintainers	For Eligible Dependent children under age 19
Full mouth / Panoramic x-rays	One every 36 months, rolling
Crowns	Once every five years per tooth
Prosthetics (Fixed)	Once every five years per unit
Inlays	Once every five years per tooth
Onlays	Once every five years per tooth
Dentures (Complete and Partial)	Once every five years Relining and rebasing is covered if done no less than six (6) months after initial placement but not more than once in any 36 month period. One replacement of a temporary denture if a permanent denture is installed within 12 months of the installment of the temporary denture.

HOW TO USE YOUR BENEFIT BOOK

This Benefit Book describes your dental benefits. Please read it carefully.

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

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

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

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

The **Exclusions** section lists services which are not covered in addition to those listed in the Dental Benefits section.

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

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DEFINITIONS

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

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

Benefit Book - this document.

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

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

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

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

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

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

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

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

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

Covered Charges - the Billed Charges for Covered Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Incurred - rendered to you by a Dental Provider.

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

Lesser Amount - for PPO Network Providers, the Lesser Amount means the Lesser of the Negotiated Amount or the Covered Charges. For Non-PPO Network Providers, the Lesser Amount means the Fee Schedule Amount.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rider - a document that amends or supplements your coverage.

Surgery -

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

ELIGIBILITY

Enrolling for Coverage

Prior to receiving this Benefit Book, you enrolled, and were accepted or approved by your Group for individual coverage or family coverage. For either coverage, you may have completed an Enrollment Form. There may be occasions when the information on the Enrollment Form is not enough. The Group will then request the additional data needed to determine whether your dependents are Eligible Dependents, or if certain conditions will not be covered during the Preexisting Condition Exclusion Period, if applicable.

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

Eligible Employee

An Eligible Employee is:

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

Eligible Dependents

An Eligible Dependent is:

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

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

Child Support Order

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

Effective Date

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

Changes in Coverage

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

Coverage for a spouse and other dependents who become eligible by reason of marriage will be effective on the date of the marriage if a request for their coverage is submitted to the Group within 31 days of the marriage. A newborn child or an adopted child will be covered as of the date of birth or adoptive placement, provided that you request enrollment within 31 days of the date of birth or adoptive placement. Coverage will continue for an adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

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

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

Your Identification Card

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

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

- Orthodontic services consisting of installing tooth straightening appliances and all treatments for abnormally positioned teeth, are subject to the following limitations:
 - Benefits for Orthodontic services will be provided only as services are Incurred.
 - When you are already receiving Active or Retention Treatment on your Effective Date, only services Incurred after your Effective Date will be covered based on a proration of the expected months of treatment.

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EXCLUSIONS

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

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

GENERAL PROVISIONS

How to Apply for Benefits

Notice of Claim; Claim Forms

A claim must be filed for you to receive benefits. All PPO Network Providers and many Non-PPO Network Providers will submit a claim for you; if you submit it yourself, you should use a claim form. In most cases, you can obtain a claim form from your Group or Dental Provider. If your Dental Provider does not have a claim form, Medical Mutual will send you one. Call or notify Medical Mutual, in writing, within 20 days after receiving your first Covered Service and Medical Mutual will send you a form or you may print a claim form by going to www.medmutual.com/member.

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

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

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

How Claims are Paid

Benefit Period Deductible

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

The Schedule of Benefits may specify a single Deductible and a family Deductible. The single Deductible is the amount each Covered Person must pay, but the total amount the family must pay is limited to the family Deductible.

For Covered Charges Incurred during the last three months of the Benefit Period, any amount applied to your Deductible will also apply to the Deductible for the next Benefit Period.

Coinsurance

After you meet your Deductible, you are responsible for Coinsurance amounts, subject to any limitations set forth in your Schedule of Benefits.

Schedule of Benefits

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

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

Your Financial Responsibilities

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

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

Direction of Payment

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

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

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

Benefit Verification

Benefit Verification determines if proposed dental treatments:

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

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

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

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

If you select the more costly treatment or service, you are responsible for all charges in excess of the allowable amount deemed Clinically Necessary by Medical Mutual. You are also responsible for Excess Charges if alternate benefits are applied, even if a PPO Network Provider is used. If the services are provided by a Non-PPO Network Provider, you may be responsible to pay the difference between the charges for the higher level of service and the benefits the Plan will provide for the lower level of service. If you receive services from a Non-PPO Network Provider and Medical Mutual has not received Benefit Verification, you may be responsible for the entire cost of the services provided.

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

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

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

Explanation of Benefits

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

Time of Payment of Claims

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

Filing a Complaint

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, the Card Holder should have the following information available:

- name of patient
- identification number
- claim number(s) (if applicable)
- date(s) of service

If your complaint is regarding a claim, a Medical Mutual Customer Service representative will review the claim for correctness in processing. If the claim was processed according to terms of the Plan, the Customer Service representative will telephone the Card Holder with the response. If attempts to telephone the Card Holder are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the Card Holder will receive a check, Explanation of Benefits or letter explaining the revised decision.

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

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

Filing an Appeal

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

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

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

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

First Level Mandatory Appeal

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

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

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

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

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

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

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

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based;
- your right to bring a civil action under federal law following the denial of a claim upon review;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, then that information will be provided free of charge upon written request;
- If the claim was denied based on a Clinical Necessity or Experimental treatment or similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination in applying the terms of the plan to the circumstances will be provided free of charge upon request;
- upon specific written request from you, provide the identification of the dental or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Voluntary Second Level Appeal

Unless your Group requires you to use an alternative dispute resolution procedure, if your first level mandatory appeal was denied, you have the option of a voluntary second appeal by Medical Mutual. All requests for appeal may be made by calling or writing to Customer Service. You may submit additional written comments, documents, records, X-rays, photographs and other information relating to the claim being appealed.

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

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

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

Claim Review

Consent to Release Medical and Dental Information - Denial of Coverage

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

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

Right to Review Claims

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

Dental Examination

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

Legal Actions

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

Coordination of Benefits

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

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

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

Plans That Do Not Coordinate Benefits

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

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

How The Plan Pays As Primary

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

How The Plan Pays As Secondary

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

Which Health Care or Dental Plan is Primary?

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

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

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

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

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

Coordination Disputes

If you believe that the Plan has not paid a COB claim properly, you should attempt to resolve the problem by contacting Medical Mutual or your Group.

Provision Enforcement

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

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

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

Facility of Payment

If payment is made under any other health care or dental plan which the Plan should have made under this provision, then the Plan has the right to pay whoever paid under the other health care or dental plan; the Plan will determine the

necessary amount under this provision. Amounts so paid are benefits under this Benefit Book and the Plan is discharged from liability to the extent of such amounts paid for Covered Services.

Right of Recovery

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

Right of Subrogation and Reimbursement

Subrogation and Right of Reimbursement

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

Reimbursement

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

Your Duties

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

Discretionary Authority

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

Changes In Benefits or Provisions

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

Termination of Coverage

How and When Your Coverage Stops

Your coverage under the terms and conditions, as described in this Book, stops:

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

Federal Continuation Provisions - COBRA

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

When You Are Eligible for COBRA

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

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

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

In the case of an Eligible Dependent of a Card Holder, (active employee or Eligible Dependent of a Card Holder covered by the Plan, he or she has the right to continuation coverage if group dental coverage under the Plan is lost for any of the following reasons:

1. the death of the Card Holder;
2. the termination of the Card Holder's employment (for reasons other than gross misconduct) or reduction in the Card Holder's hours of employment;
3. the Card Holder's divorce or legal separation;
4. the Card Holder becomes entitled (that is, covered) under Medicare;
5. the dependent ceases to be an "Eligible Dependent;" or
6. the Card Holder is retired and the Card Holder's group files for reorganization under Chapter 11 of the Bankruptcy Code.

Notice Requirements

Under COBRA, the Card Holder or Eligible Dependent has the responsibility to inform the Group of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of any such event. If notice is not received within that 60-day period, the dependent will not be entitled to choose continuation coverage. When the Group is notified that one of these events has happened, the Group will, in turn, have 14 days to notify the affected family members of their right to choose continuation coverage. Under COBRA, you have 60 days from the date coverage would be lost because of one of the events described above or the date of receipt of notice, if later, to inform your Group of your election of continuation coverage.

If you do not choose continuation coverage within the 60-day election period, your group dental coverage will end as of the date of the qualifying event.

If you do choose continuation coverage, your Group is required to provide coverage that is identical to the coverage provided by the Group to similarly situated active employees and dependents. This means that if the coverage for similarly situated Covered Persons is modified, your coverage will be modified.

How Long COBRA Coverage Will Continue

COBRA requires that you be offered the opportunity to maintain continuation coverage for 18 months if you lost coverage under the Plan due to the Card Holder's termination (for reasons other than gross misconduct) or reduction in work hours. A Card Holder's covered spouse and/or Eligible Dependents are required to be offered the opportunity to maintain continuation coverage for 36 months if coverage is lost under the Plan because of an event other than the Card Holder's termination or reduction in work hours.

If, during an 18-month period of coverage continuation, another event takes place that would also entitle a qualified beneficiary (other than the Card Holder) to his own continuation coverage for up to 36 months from the date of entitlement (for example, the former Card Holder dies, is divorced or legally separated, becomes entitled to Medicare or the dependent ceased to be an Eligible Dependent under the Plan), the continuation coverage may be extended for the affected qualified beneficiary. However, in no case will any period of continuation coverage be more than 36 months.

If you are a former employee and you have a newborn or adopted child while you are on COBRA continuation and you enroll the new child for coverage, the new child will be considered a "qualified beneficiary." This gives the child additional rights such as the right to continue COBRA benefits even if you die during the COBRA period. Also, this gives the right to an additional 18-month coverage if a second qualifying event occurs during the initial 18-month COBRA period following your termination or retirement. If you are entitled to 18 months of continuation coverage and if the Social Security Administration determines that you were disabled within 60 days of the qualifying event, you are eligible for an additional 11 months of continuation coverage after the expiration of the 18-month period. To qualify for this additional period of coverage, you must notify the Group within 60 days after becoming eligible for COBRA or receiving a disability determination from the Social Security Administration, whichever is later. Such notice must be given before the end of the initial 18 months of continuation coverage. If the individual entitled to the disability extension has non-disabled family members who are qualified beneficiaries and have COBRA coverage, those non-disabled beneficiaries will also be entitled to this 11-month disability extension. During the additional 11 months of continuation coverage, the premium for that coverage may be no more than 150% of the coverage cost during the preceding 18 months.

The law also provides that your continuation coverage may be terminated for any of the following reasons:

1. your Group no longer provides group dental coverage to any of its employees;
2. the premium for your continuation coverage is not paid in a timely fashion;

3. you first become, after the date of election, covered under another group dental plan (unless that other Plan contains an exclusion or limitation with respect to any preexisting Condition affecting you or a covered dependent); or
4. you first become, after the date of election, entitled (that is covered) under Medicare.

Additional Information

An Eligible Dependent who is a qualified beneficiary is entitled to elect continuation of coverage even if the Card Holder does not make that election. At subsequent open enrollments, an Eligible Dependent may elect a different coverage from the coverage the Card Holder elects.

You do not have to provide proof of insurability to obtain continuation coverage. However, under COBRA, you will have to pay all of the premium (both employer and employee portion) for your continuation coverage, plus a 2% administrative fee. You will have an initial grace period of 45 days (starting with the date you choose continuation coverage) to pay any premiums then due; after that initial 45-day grace period, you will have a grace period of 30 days to pay any subsequent premiums. (During the last 180 days of your continuation coverage period, you must be allowed to enroll in an individual conversion health plan if one is provided by the Group. However, conversion coverage is not available if the Agreement terminates or the Group goes out of business. Call the Group during your last 180 days of COBRA for information on conversion).

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

Continuation of Coverage During Military Service

If you go on active duty in the U.S. armed forces, you will cease to be covered under the regular group health plan as of the end of the month in which you enter active military service. However, you have the following rights to continue coverage:

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

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