



Member Handbook



health plans for life

This handbook is for individuals enrolled in either the SuperMed Plus® or SuperMed Classic® health plans. Please note the differences that are explained in the section *Choosing a Physician*.

This handbook includes information to help you get the most value from your health plan. Please take time to read through it carefully and keep it for reference. A copy of this handbook is also available in the Member Services section of our Web site, www.MedMutual.com.

In addition, please visit our Web site for the most up-to-date information about Medical Mutual™, our physicians and hospitals, and many other Member services. While in our Web site, you will find important links that can help you with your healthcare needs.

- **SaveWell™** is an innovative program providing significant discounts on healthcare needs. SaveWell is not insurance, but does offer discounts on prescriptions and other healthcare expenses. To enroll in SaveWell, go to the Our Plans section of our Web site, and select the SaveWell link. Or, log on to www.SaveWell.com.
- Medical Mutual, through its partnership with **WebMD®**, provides health and wellness news and information to all members. By selecting the WebMD link on our Web site, you can access health information about many topics. While in *My Health Plan*, you have further access to other innovative features such as health risk assessments, health management tools and interactive health improvement guides.

This handbook is not intended to be a summary of benefits or coverage. All benefit and coverage provisions are contained in your plan certificate and are effective as long as you are an active Member with the health plan. In case of any conflict, the terms of the plan certificate prevail.

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www.MedMutual.com

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Questions? Changes?

Here is an important list of whom to contact if you have questions or changes regarding your health plan:

Customer Service: Call the Customer Service telephone number on your identification card if you have questions about:

- Benefit coverage
- Medical Mutual's services
- Selecting a network physician, hospital or ancillary provider
- Your identification card
- Your Explanation of Benefits (EOB), or a bill
- Changing your name, address, telephone number or family status
- A physician's credentials or medical education
- Voicing a complaint or filing an appeal
- Obtaining a copy of the preferred prescriptions list
- Special needs or preferences, including language or cultural needs

You can also visit the Members' section of our Website at www.MedMutual.com and register on *My Health Plan*. You will be able to:

- Change your address or phone number
- Order a new identification card
- Check the status of your claim or print a claim form
- Reprint an Explanation of Benefits (EOB)
- Order a plan certificate
- Find a healthcare provider or pharmacy located near you
- Get a list of preferred prescription medications
- Print a temporary identification card
- Submit a request for an appeal
- E-mail Customer Service with questions or recommendations regarding Medical Mutual's policies, practices and services; file a complaint; or update your other insurance information

Emergencies: If necessary, call 911. You should always seek immediate treatment at the nearest emergency room.

Network Providers: Call 1-888-241-2583 to obtain a network provider directory. This number can also be found on your identification card. Or, log on to www.MedMutual.com under the Members' section and search for a network physician, hospital or ancillary providers, including ambulance services. The online directory can also help you identify a network physician who speaks a particular language or is able to address other special needs and preferences.

Inpatient Hospital Admissions, Acute Rehabilitation Admissions, Skilled Nursing Facility Admissions, Home Healthcare Services and Behavioral Health Admissions: Medical Mutual's contracted providers are responsible for completing precertification requirements on the Member's behalf. If you are traveling or using a non-network provider, call the Care Management telephone number on your identification card.

Welcome to SuperMed



As a Medical Mutual Member, you benefit from the experience of a health insurance company that has been providing innovative, quality benefits and services since 1934.

SuperMed Classic coverage combines the flexibility of choosing any physician with the cost advantages of using the SuperMed hospital network.

SuperMed Plus is a preferred provider organization (PPO) plan that features a network of respected hospitals and physicians who are easily accessible to you and your family.

SuperMed Classic and SuperMed Plus are accredited for utilization review activities by the American Accreditation HealthCare Commission/URAC. In addition, the SuperMed Plus plan is accredited by the National Committee for Quality Assurance (NCQA). NCQA and URAC are independent, not-for-profit organizations dedicated to measuring the quality of America's healthcare. Medical Mutual maintains high quality practices in the areas of credentialing, medical records, Members' rights and responsibilities, preventive healthcare, quality improvement and utilization management.

Medical Mutual provides you with choice, flexibility and direct access to care from any SuperMed healthcare provider. To maximize your benefits, select any physician, hospital or ancillary provider in SuperMed's extensive network. With both SuperMed Classic and SuperMed Plus, you may also receive care from a provider outside the SuperMed network, but your out-of-pocket costs will increase.



*SuperMed is the easy-to-use,
helpful healthcare plan.*

To get the most value from your Medical Mutual coverage, familiarize yourself with the following items:

- The *identification card* issued to you is your proof of insurance and should be presented every time you receive medical services. The card includes a Customer Service telephone number that you can call for information or answers to questions about your health plan. The Care Management telephone number can be used for notifying Medical Mutual of services that require precertification.
- A *network directory* is a comprehensive list of physicians, hospitals and ancillary providers specific to your health plan that you may use for medical services and treatment. You can obtain a directory by calling the network provider directory telephone number on your identification card. You may also search for a physician, hospital or ancillary provider by visiting the Members' section of our Web site at www.MedMutual.com, or by clicking on the link at the top of the home page.
- Your *plan certificate* contains detailed information about your healthcare benefits.

Definitions

Ancillary providers: Providers, agencies or services that supplement the care normally given by physicians or hospitals, such as laboratories, durable medical equipment agencies, oxygen or respiratory therapy providers, and rehabilitative or therapy services.

Authorize: The act of approving care determined to be medically necessary, such as a hospital admission, subject to confirmation of the services that you received. NOTE: Services approved based on medical necessity should be checked for benefit coverage and eligibility by contacting Customer Service.

Behavioral Healthcare: The evaluation and treatment of disorders relating to the human mind and substance abuse.

Benefits Manager: The individual at a company who helps administer an employer's healthcare plan, sometimes referred to as the Group or Plan Administrator.

Benefit Period: The period of time during which benefit maximums, deductibles and coinsurance limits accumulate. A benefit period is a calendar year, unless otherwise specified in your plan certificate.

Care Management: The process used by Medical Mutual to review medical services received or to be received by Members, and to make certain that medically necessary, appropriate treatment is provided.

Coinsurance: If applicable, the percentage of the cost you pay for covered medical services after you have met your deductible or paid your copayment. This amount is defined in your plan certificate.

Contracting: A hospital or other facility provider that has an agreement with Medical Mutual regarding payment for covered services.

Copayment: If applicable, the amount of money you pay each time you receive medical services. A copayment can be a specific dollar amount paid at the time a service is received as defined in your plan certificate.

Deductible: The set dollar amount that you must pay, if applicable, for services covered by your health plan during each benefit period before Medical Mutual begins making payment. There are single and family deductibles. If you have covered dependents, you will have a family deductible.

Explanation of Benefits (EOB): A form that details the amounts paid to you and/or your healthcare provider after you receive healthcare services. The EOB contains information on how your claim was paid.

Health Plan: An organization that offers healthcare services. It can be an HMO, point-of-service plan, a preferred provider organization, a commercial insurer or a company that self-insures. Also called a Carrier.

Member: The plan certificate holder and his or her eligible family Members enrolled in the health plan.

Network: The hospitals, physicians, laboratories and other healthcare professionals or facilities selected to contract with Medical Mutual for participation in the health plan. Medical Mutual's network is known as the "SuperMed" network. Medical Mutual contracts with numerous other regional networks to offer services.

Non-network Provider: Any hospital, physician, laboratory or other healthcare professional or facility that does not have a network contract with Medical Mutual.

Non-participating Provider: A physician, lab or other healthcare professional provider that does not have an agreement with Medical Mutual regarding payment for covered services. The Member may be liable for any amount of billed charges over Medical Mutual's usual, customary and reasonable (UCR) rate, or for services denied as not medically necessary.

Participating Physician/Healthcare Professional: A physician or healthcare professional who has signed an agreement to accept Medical Mutual's UCR

rates as payment-in-full for covered services. The Member is not liable for any amount charged over the UCR rate or denied as not medically necessary.

Physician Hospital Organization (PHO): An organization that is formed between a hospital and its medical staff(s) to contract jointly with a managed care organization.

Plan Certificate: The document identifying the terms, conditions and limitations of insurance benefits provided by the health plan to its Members. Sometimes called a Policy.

Practitioner: A licensed professional who provides healthcare services.

Precertification: The act of notifying Medical Mutual's Care Management department of an upcoming medical need. Typically, contracting healthcare facilities and professionals perform precertification. Precertification is designed to reduce unnecessary hospital admissions and to ensure that healthcare services are medically appropriate and delivered in the most cost efficient manner, keeping quality, as well as cost, in mind. Precertification does not guarantee payment. Payment is subject to the covered person's contract provisions. If using a non-SuperMed network provider, the Member is responsible for the precertification process.

Predetermination: Like precertification, it is a request for review of certain services or procedures, prior to receiving those services, to determine if they are appropriate. It is not a guarantee of payment. Payment is subject to the Member's benefits. Procedures such as solid organ transplants, bone marrow transplants and surgeries that may be cosmetic/reconstructive in nature are a few examples of procedures requiring predetermination.

Preferred Provider Organization (PPO): A network of physicians and hospitals that offers care at a lower cost than traditional insurance. Members enrolled in a PPO receive the highest level of benefits when they receive care from a PPO network provider and pay higher out-of-pocket costs if they go outside the PPO network.

Provider: Any licensed healthcare professional or facility that provides care. Examples of providers are physicians, specialists, hospitals, skilled nursing facilities and laboratories.

Specialist: A type of physician who can provide care in a particular medical specialty other than family practice, general or internal medicine, or pediatrics. Common areas of specialty include dermatology, urology, cardiology and psychiatry.

Usual, Customary and Reasonable (UCR) Rate: The maximum amount allowed for a covered service provided by a physician or other professional provider

based on the following criteria: (1) The UCR amount will never exceed the actual amount billed by the physician or other professional provider for a given service, and for some services may be the amount billed. (2) The UCR amount may be limited to the customary charge based on the distribution of charges billed by all physicians and other professional providers for a given service within a given specialty and geographic area. (3) The UCR amount must also be reasonable to Medical Mutual with respect to customary charges or costs for services of comparable complexity and difficulty.

Helpful Hints

- Carry your identification card at all times. You never know when the need for medical care might arise.
- Be sure to visit our Web site, www.MedMutual.com, and register on *My Health Plan* to access more information about your own healthcare plan.
- Review your Medical Mutual plan certificate, network directory and Member handbook before seeking care so you can get the most value from your coverage.

Your Rights and Responsibilities

Medical Mutual Members have the right to:

- Quality healthcare practitioners, hospitals and other facilities
- Emergency medical care
- Information about their healthcare practitioners, benefits, health promotion, illness prevention and treatment options regardless of cost or benefit coverage
- Courteous and respectful care and service
- Privacy and confidentiality in the use of their personal and medical information and records, and the option to request confidential communications
- Request and receive a copy of their protected health information and to amend their protected health information for corrections and/or omissions

- Request an accounting of protected health information disclosures outside of routine uses, to complain about privacy violations and to receive a Notice of Privacy Practices
- Authorize or deny release of personal health information beyond use for treatment, payment or healthcare operations
- Exercise all federal and state rights, including rights under the Health Information Portability and Accountability Act (HIPAA), without fear of retaliation or condition of payment. Members will not be required to waive their rights in order to be provided benefits.
- Be informed and responsible participants with their practitioners in decisions affecting their healthcare
- Refuse medical treatment
- Prompt, accurate payment of their claims in accordance with the terms of their policies
- Prompt and courteous response to concerns, questions and complaints which may arise in the course of purchasing and utilizing our insurance plans and services, and to appeal any decision
- If covered by an insured program, request a review by the department of insurance if Medical Mutual denies, reduces or discontinues coverage for a healthcare service because the company determined that the service was not covered as part of the health plan or not medically necessary
- Ask and be informed about business relationships between Medical Mutual and the practitioners, hospitals and other healthcare providers and facilities that may influence Members' treatment and care
- Access a full range of care and receive the proper care at the right time and place
- Make recommendations regarding the Members' rights and responsibilities policies

Medical Mutual Members have the responsibility to:

- Cooperate with their healthcare practitioners in following the prescribed care plan to which they have agreed
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible
- Promptly pay appropriate copayments, coinsurance and deductibles

- Provide to Medical Mutual and to healthcare practitioners the information needed to provide proper care and to appropriately administer claims, payment and coordination with other payers

Changing Your Information

Maintaining current information about Members is important. For changes to your name, address or telephone number, notify your company's benefit manager, call Customer Service or visit *My Health Plan* at www.MedMutual.com.

When there is a change in your family or dependent status, such as the birth of a baby, adoption of a child, marriage, divorce or death, you should immediately notify your company's benefits manager, who will notify Medical Mutual. If you are not employed or are self-employed, please notify Customer Service within 31 days of the change. Failure to promptly report the change of family status to Medical Mutual can delay or cause denial of healthcare coverage.

Privacy and Confidentiality of Members' Personal Health Information

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

IMPORTANT NOTICE TO ALL INSURED

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

Your Privacy Is Important to Us

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

What Information We Collect

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

How We Use and Disclose Your Information

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

Payment: Medical Mutual may use or disclose your information to pay claims for covered services or to provide eligibility information to your doctor when you receive treatment.

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

As Required by Law: Medical Mutual must allow the U.S. Department of Health and Human Services access to audit its records. In addition,

Medical Mutual may be required to release your information to comply with other laws:

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

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

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

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

- To your personal representative appointed by you or designated by law
- To appropriate military authorities, if you are a member of the armed forces

- To a family member, friend or other person for the purpose of helping you with your healthcare or healthcare payment if you are in an emergency situation and you cannot give your agreement to Medical Mutual to do this
- To inform you of other health-related benefits or services that may be of interest to you

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

Your Rights

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

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

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

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

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

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

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

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

Disclosures: You have the right to an accounting of certain disclosures of your information made by Medical Mutual and its Business Associates over the last six (6) years (but not for disclosures made before April 14, 2003). All requests must be made in writing and include your name, your birthday, the policy number under which you are covered and a statement explaining your specific request.

Complaints: You have the right to complain if you believe your rights have been violated. All complaints will need to include the following information: your name, your birthday, the policy number under which you are covered and an explanation regarding your complaint in as much detail as possible. You may file a complaint by contacting Customer Service if you do not wish to send it in writing.

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

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

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

Helpful Hints

- For copies of all privacy and confidentiality forms referred to in the Privacy Notice, be sure to visit the Members' section of our Web site at www.MedMutual.com.
- Persons insured under the same contract do *not* need written authorization to access information about each other, for example, when calling Customer Service.
- Because Medical Mutual does *not* sell your personal health information, Members do not need to fill out a form to request confidential communications for this reason.
- Please remember that Post Office Box 89499 is to be used *only* for submitting Privacy and Confidentiality forms. Sending other inquiries or claims to this post office box will delay processing your request. Refer to your identification card for the address to use for sending correspondence or claims to Medical Mutual.

Choosing a Physician

Your health plan offers flexibility in selecting physicians for medical services. As a SuperMed Plus or SuperMed Classic plan Member, you are not required to notify Medical Mutual or register your physician selection.

If you are a SuperMed Classic Member, you can receive medical care from any physician or healthcare professional you choose. However, to receive the highest level of benefits from your health plan, you and your covered family Members should use SuperMed hospital network providers or participating physicians/healthcare professionals.

If you are a SuperMed Plus Member, you and your covered family Members will receive the highest level of benefits from your health plan by receiving all medical services from any of the hospitals or physicians listed in the SuperMed Plus network directory or in the *Find a Provider* tab in the Members' section of our Web site.

Your health plan's directory includes a list of physicians by county to help you select a doctor located near you. The list also includes hospitals where these doctors can admit patients and, if applicable, the physician hospital organization (PHO) to which the physicians belong. This list also helps to ensure you choose physicians, physician office locations and hospitals that are part of your health plan's network. If you do not see your desired physician or desired office location listed in the network directory, please visit the Members' section of our Web site at www.MedMutual.com, or call Customer Service to confirm that the physician or the office is part of the SuperMed network or one of our regional network of providers. Always be sure to select a physician who participates in the SuperMed network or one of Medical Mutual's regional networks to receive the highest level of benefits.



Physician listings include name, address, certification, affiliation and specialty.

All physicians and hospitals participating in the network agree to accept payment from Medical Mutual as payment-in-full for covered services, less any



applicable deductible, copayment and/or coinsurance amounts described in your plan certificate. You are not responsible for any charges in excess of Medical Mutual's negotiated rate when using a network provider. For further information on deductibles, copayments and coinsurance, please see the section on *Medical Care Costs* in this handbook.

Physicians' Qualifications

Your SuperMed network directory lists the board certification status of the physicians in the network. However, if you have additional questions about a physician or a specialist listed in the network directory, such as his or her credentials or medical education, please feel free to call the doctor's office, or call Customer Service.

There are many sources for you to check a physician's qualifications and certification status. These sources are available at your local library, by telephone or on the Internet — whichever is most convenient for you:

- Your local Academy of Medicine, listed in your telephone directory
- State medical boards
- The Directory of Medical Specialists, available at most public libraries
- The AMA Physician Select Web site, www.ama-assn.org, the American Medical Association's free physician information service



Receiving Medical Care

Medical Mutual's health plans include coverage for many medically necessary services. A medically necessary service is one that is required to diagnose or treat a medical condition and is more fully defined in your plan certificate.

There are certain services that require you to pay a copayment, coinsurance or deductible. For a clear understanding of covered services and your financial responsibilities, please review your plan certificate.

Care in Progress

If you have recently joined Medical Mutual's health plan and are receiving treatment from a provider who is not in the SuperMed network of physicians or hospitals, you may be in a situation known as *transitional care*.

Transitional care is when you are receiving treatment from one doctor and switch to another provider before completing your treatment. An example of transitional care is the treatment of cancer. If you join the health plan and are being treated for a condition such as cancer, you should notify your physician and our Care Management department to find a SuperMed network physician, or a physician in one of Medical Mutual's regional networks, who can treat your condition and help arrange the transitional care period. If you choose to stay with a non-network physician, you may pay a higher out-of-pocket cost as described in your plan certificate.

If you are pregnant and receiving care, you may continue to see the same OB/GYN specialist you have been seeing through the course of your pregnancy. However, if the OB/GYN specialist is not a SuperMed network physician or a physician in one of Medical Mutual's regional networks, you may pay a higher out-of-pocket cost as described in your plan certificate. Please call the Care Management department's precertification telephone number listed on your identification card to arrange for your transitional care needs.

Helpful Hints

- Refer to your directory before choosing a physician, or call Customer Service at the telephone number on your identification card. You can also visit www.MedMutual.com to search for a physician or hospital.
- Use a physician and hospital in the SuperMed network or one of Medical Mutual's regional networks to get the most value from your healthcare plan. Check your identification card for the name of the regional network of providers closest to you.
- Make sure your new physician has a copy of your medical records from your previous physician.

Specialty Care

For most Members, the physicians and facilities within the extensive SuperMed network can meet all healthcare needs. Be sure to check if the specialist's location is an approved network location. If you need specialized services that are not available within the network, contact Care Management at the precertification telephone number on your identification card before scheduling an appointment.

If you require healthcare services that are available in the network, but choose to receive treatment from a non-network provider, you will still receive benefits for covered services, but at the reduced level specified in your plan certificate.

When you see a specialist, it is important for the specialist to send your regular physician information detailing the findings and any necessary treatment. At the end of your visit, remind the specialist to send your physician a letter and copies of any reports.

NOTE: If your physician is a member of a PHO, the doctor should send you to a SuperMed network specialist within the PHO's network to receive maximum benefits. The name of the PHO will be listed under the physician's name in the network directory.

Hospital Stays

Before entering the hospital, confirm that the hospital is part of the SuperMed network or one of Medical Mutual's regional networks by checking your specific health plan directory, going to the Members' section of www.MedMutual.com or calling Customer Service.

Providers who are contracted with Medical Mutual are responsible for completing precertification requirements on the Member's behalf. However, if you are traveling or are using a non-network or non-participating provider, call the appropriate Care Management telephone number on your identification card to precertify an inpatient stay. Medical Mutual will cover only those hospital stays that are precertified by the admitting hospital for medical necessity or that are emergencies.

After-hours Care

If you need medical or behavioral healthcare after office hours, you should contact your physician for advice or to schedule an appointment in his or her office. If you have a medical emergency, go to the nearest hospital emergency room. If you have an illness or an accident that requires prompt medical attention, but is not life threatening, you should seek the advice of a physician or go to an appropriate urgent care facility that can treat that condition. A SuperMed network physician is on call 24 hours a day, seven days a week. The available physician will direct you to the nearest hospital emergency room or urgent care center, or schedule an appointment in his or her office. Remember that obtaining care from a participating network provider will result in lower out-of-pocket costs.

Care When You Travel

Your health plan provides important coverage for you through a network of regional providers when an illness or accident occurs away from home. Simply call the Customer Service telephone number for the appropriate state listed on your identification card between the hours of 8:00 a.m. and 5:00 p.m., Eastern Standard Time, Monday through Friday, to locate a network physician, facility, or ancillary provider, or to ask questions regarding eligibility of benefits. Or, to locate a provider, visit www.MedMutual.com, under the *Find a Provider* tab in the Members' section. Your identification card also shows which network to use for the state indicated.

In the case of a medical emergency, you should seek care at the nearest hospital and follow the same procedures as you would at home. *Emergency ambulance* services are normally covered at the highest level of benefit according to your plan certificate, provided they are medically necessary and take you to the closest facility that is equipped to offer the necessary care. *Air ambulance* is only covered when it is medically necessary to be transported by air to the nearest facility that can provide the services.

Check your plan certificate for your particular benefit coverage for emergency and ambulance services.

Remember, if you are admitted to a non-contracting hospital or any facility that is *not* in the SuperMed network, you are responsible for the precertification process. To precertify an admission, call the Care Management

department's precertification telephone number on your identification card between the hours of 8:15 a.m. and 4:15 p.m., Eastern Standard Time, Monday through Friday. If you are admitted at a time other than this and cannot reach a Medical Mutual representative, please call on the next business day. Medical Mutual will retrospectively review the service for medically necessary care. Only services that are determined by Medical Mutual to be medically necessary will be covered. You will be responsible for all charges deemed by Medical Mutual as not medically necessary.

Please be aware that, when using non-network or non-participating providers, you may be required to pay the entire cost of the medical services before they are received, and then be reimbursed by Medical Mutual for medically necessary, covered services. Ask the non-network or non-participating provider to submit a detailed bill and medical report directly to the claims submission address on your identification card. If medical services were performed outside of the United States, ask the provider for your own copy of all medical records. Claim forms completed in a language other than English should be translated into English before submitting to Medical Mutual. Medical Mutual's address for submitting a claim is on your identification card. Please refer to your plan certificate or call Customer Service for specific benefit information and out-of-pocket costs while traveling outside the United States.

Prescription Drugs

Medco Health Solutions Inc. is the pharmacy benefits manager for Medical Mutual. Medco Health Solutions operates its retail pharmacy program under the name Medco Health and its mail-order program under the name Medco Health Home Delivery Pharmacy Service.

If you have prescription drug coverage as part of your health plan, you may be enrolled in one or both of the following programs, which are defined in your plan certificate:

- **Retail Prescription Drug Program:** If you have prescription drug coverage, show your Medical Mutual identification card to the pharmacist at a network pharmacy when purchasing prescription drugs. This coverage will include a copayment when you purchase your prescriptions. For convenience and economy, it is important to use a network pharmacy where your claims will be submitted electronically and your benefits will be paid at the highest level.
- **Mail-Order Prescription Drug Program:** A convenient mail-order service is beneficial for those who take medications regularly for chronic conditions. If your physician prescribes this type of medication, you may want to use the mail-order program if you have prescription drug coverage. This program includes a copayment.

These programs may include voluntary preferred prescription programs or formularies, which are lists of commonly prescribed medications selected by healthcare professionals based on clinical and cost effectiveness. You can save money by asking your doctor to prescribe these preferred medications. Your specific prescription formulary may be found on your identification card. Questions regarding your specific formulary may be answered by calling Customer Service, by visiting the Medco Health Solutions Web site at www.medcohealth.com, or through the Member Services section at www.MedMutual.com.

Please be aware that some medications have quantity limits and may require pre-authorization before your prescription can be filled. Medical Mutual does not cover products that are approved by the Federal Drug Administration for cosmetic use or weight loss.

If you have questions about your coverage and need to speak to a Customer Service representative, please call one of the following telephone numbers:

- If your benefits require you to pay only a copayment for your prescriptions at the retail or mail-order pharmacy, please call Medco Health Solutions at 1-800-417-1961.
- If your benefits require you to pay for the entire cost of the prescription at the retail or mail-order pharmacy and then receive reimbursement from Medical Mutual, please contact Customer Service.



Receiving Appropriate Care

Care Management is the process used to review medical services received by Members and to verify that medically necessary treatment is provided. This process often applies to hospital stays. If you are seriously ill, Care Management staff may also work with your physician to help you get the care and coverage needed.

Staff in the Care Management department are available during normal business hours to deal with questions about your *specific* case, which may include reasons for denial, or information on the time period approved for a hospital stay or course of treatment. Call the appropriate precertification number on your identification card to speak with a healthcare professional about your specific situation. If you have *general* questions about the Care Management process, such as if a service requires an initial review by Care Management, you may call Customer Service.

The goals of Care Management are to promote high quality healthcare and to eliminate inappropriate services and costs. In addition, Care Management promotes and encourages the use of preventive health practices through the development and distribution of Preventive Care Guidelines. To receive a copy of the guidelines, visit the Health and Wellness section of our Web site at www.MedMutual.com, or write to or call:

The Clinical Quality Improvement Department
Medical Mutual
MZ: 01-5B-7501
2060 East Ninth Street
Cleveland, OH 44115-1355
1-800-586-4523

Please note that to ensure all members receive the most appropriate medical care available, Medical Mutual requires all employees, contracted physicians and management staff who deal with utilization review activities to sign a statement acknowledging their understanding of the following statements:

- Utilization management decisions are based only upon the appropriate use of care and services for the member.
- Medical Mutual does not directly or indirectly reward or incent providers' or any other individuals' participation in utilization review decisions for denying or limiting coverage or service.
- Medical Mutual does not provide financial incentives for utilization management decisions that result in the under-utilization of care or service.

Helpful Hints

○ Preventive Health Screenings

Although Medical Mutual recognizes the importance of certain health screening examinations, it is important to remember that payment for recommended services is subject to your benefits as described in your plan certificate.

Services for Mental Health and Substance Abuse

Medical Mutual covers many services for the treatment of mental health disorders and substance abuse. In most cases, treatment can be given on an outpatient basis under the direction of a SuperMed provider or one of Medical Mutual's regional providers. However, if you, a family member, your physician or counselor feel that inpatient hospital care for an acute or urgent situation may be necessary, please remember that any admission must be precertified by Medical Mutual's Care Management department. Also, please be aware that residential care is normally not a covered benefit in all health plans. Refer to your plan certificate for your specific mental health and substance abuse benefits and the list of Benefit Exclusions.

Helpful Hints

- Residential care is typically provided by a freestanding, licensed agency that provides services 24 hours a day, seven days a week. This treatment is commonly reserved for those cases when the patient has not responded to acute treatment because of a disturbance in behavior, age-appropriate adaptive functioning, or psychological or social functioning. Admission to a residential treatment center is considered an elective admission and is normally not a covered benefit. All stays require precertification prior to admission. Call Customer Service for questions about benefit coverage.

New Healthcare Practices

Medical Mutual is committed to providing benefits for new healthcare practices that result from scientific research. When breakthroughs develop, Medical Mutual will perform an extensive evaluation of the new use and application of medical technologies, behavioral health procedures, pharmaceuticals and devices to ensure they are medically appropriate for our Members.

After this evaluation by multiple internal and external experts, a recommendation may be made to include the new service in the coverage provided to

our Members. Coverage for new healthcare practices may be limited to specific medical conditions, age groups, gender, place, types of service or diagnosis. However, if scientific evidence shows that the drug, device, procedure or medical treatment is the subject of ongoing clinical trials, or if the consensus of opinion among experts is that further clinical trials are necessary, despite the Food and Drug Administration's approval, it may be determined to not be a covered benefit.

All policies on new healthcare practices are reviewed annually to maintain current community healthcare practices.

To receive more information regarding Medical Mutual's evaluation of emerging technology and other quality improvement activities, visit www.Med.Mutual.com or write to:

The Clinical Quality Improvement Department
Medical Mutual
MZ: 01-5B-7501
2060 East Ninth Street
Cleveland, OH 44115-1355

Emergency vs. Urgent Care

What Is an Emergency?

An emergency medical condition exhibits acute symptoms of sufficient severity, including severe pain, that a non-medical person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Examples of medical emergencies include:

- Shock
- Choking
- Chest pain
- Unconsciousness
- Poisoning
- Uncontrolled bleeding

For behavioral health, a condition that is considered an emergency is life-threatening and requires immediate psychiatric treatment to prevent death or disability.

Examples of behavioral health emergencies include:

- Attempted harm to oneself or others
- Delusions
- Hallucinations

Emergency Care

During a medical emergency, you should always seek immediate treatment at the nearest emergency room. If necessary, call 911. You or a family member should contact your physician within 24 hours of the emergency to arrange follow-up care.

If you talk to your physician during a medical emergency, he or she should see you immediately or direct you to the closest, appropriate healthcare provider. During behavioral health life-threatening emergencies, you should be directed immediately to the closest, appropriate facility for treatment. For behavioral health emergencies that are not life-threatening, you should be seen within six hours or directed to a network provider who can provide the required services.

Urgent Care

Some illnesses or accidents require prompt medical attention, but are not life-threatening emergencies. For urgent care needs such as minor sprains, cuts, injuries or mild illnesses, you should call your physician for advice on where to seek care. Your physician will either see you that day or direct you to a network provider who can see you. For an urgent condition, you should be seen within 48 hours following contact with the provider's office.

Medical Care Costs

There are some medical services that require you to pay a copayment or deductible and a coinsurance amount, and some that are not covered by your health plan. Once you meet your financial responsibilities for a specific service while using a SuperMed network provider or hospital, or one of Medical Mutual's regional network providers that is listed in your health plan directory, you are not responsible for any approved, medically necessary charges above the negotiated rates.

Checking before you have a medical procedure done can help you maximize your insurance benefits and save you from unnecessary out-of-pocket expenses. *Sometimes your doctor may recommend a procedure or service that is not covered by your insurance.* In that case, you would be responsible for

paying the *full cost* of that procedure. If you are scheduling a service in advance, it is always best to check first to make sure your insurance benefits cover what the doctor orders. Before you have a procedure done:

Check with your doctor (provider):

- Ask what is the *name of the procedure*, the *procedure code* and *diagnosis* that will be billed for the recommended procedure or service.

Check your plan certificate:

- Look at what is covered and familiarize yourself with your basic covered benefits.
- Read the list of “exclusions” to see what is *not* covered under your benefits.

Check with Customer Service:

- Tell the Customer Service representative the procedure code and diagnosis and ask:
 - Is precertification, predetermination, a referral or a second surgical opinion needed?
 - Is there a limit on frequency, quantity or age for the service?
 - Is this procedure considered cosmetic or experimental/investigational, and is it covered under your benefits?
 - Are your doctor and the facility where the service will be performed in the network?

Check your benefit period or the renewal date of your policy:

- If a group has a change in benefits or a benefit limitation, the change is usually tied to the date the coverage is renewed or the beginning of the next benefit period.



- If you don't know what the renewal and benefit period dates are, ask your group's benefit manager or our Customer Service representative.
- Deductible and coinsurance are tied to your benefit period.
- *When* you have a service done may affect the amount of out-of-pocket cost you are responsible for or if the service is covered at all.

Check back with Customer Service:

- If a "medical necessity" authorization is required, make sure an approval is on file before you have the service. This is a medical necessity determination, only.
- Payment is subject to your coverage being in effect, and the benefits you have, on the day you have the service performed, not when the service may have been authorized.

Helpful Hints

- If you obtain services from a non-network or non-participating provider, *with or without* the authorization of Medical Mutual, you may be responsible for any charge beyond Medical Mutual's negotiated rates or the difference between the UCR rate and the billed charges. You may also be responsible for all billed charges of services deemed by Medical Mutual as not medically necessary and for non-covered charges.
- If you obtain services from a non-contracting facility or institutional provider, *with or without* the authorization of Medical Mutual, you may be responsible for all billed charges of services deemed by Medical Mutual as not medically necessary and for non-covered charges.
- *Ambulance* transportation services are covered at the highest level of benefits per your plan certificate, provided that the services are medically necessary, transportation is to the closest facility that is equipped to offer the necessary care and service is rendered by a participating provider. *Air ambulance* is only covered when it is medically necessary to be transported by air to the nearest facility that can provide the services needed.

Your Explanation of Benefits (EOB)

Each time you receive a medical service, Medical Mutual will send you an Explanation of Benefits (EOB) form that explains the amounts paid to you and/or your healthcare provider. Although it may look like one, your EOB is not a bill; it is for your information and reference only.

- If you receive a bill or statement from a doctor or provider of medical services, compare it to your EOB. Check the name of the provider(s), date(s) of service and the service(s) you received to make sure that they are the same on the EOB or bill/statement.
- If a statement from your doctor shows you have a balance due, call the doctor's office and ask for the breakdown by date(s) of service and amount(s).
 - It is important for you to have a record of the date and amount of services if you have any questions in the future.
 - Ask if a payment from Medical Mutual was credited to your account. If the payment is listed on your account, compare the amount your doctor is billing you with the amount in the "Patient Responsibility" section on the right-hand side of your EOB. If the two amounts match, then your doctor is billing you correctly according to your claim.
- Read the "Remarks" on the EOB. These codes explain if any charges were denied and if you are responsible for payment. They also tell you whether or not your doctor is in the network.
- If services were denied and your EOB states that you are not responsible for these charges, but you are being billed for them, check with your doctor – it may be a simple mistake. You can also call, write or e-mail Customer Service. When calling, have your EOB and billing statement in hand with all of the necessary information.

For a complete explanation of the services covered, your financial responsibilities and the administrative procedures that ensure prompt payment of claims, please review your plan certificate or call Customer Service.

Deductibles, Copayments and Coinsurance

The following is a simplified example of how deductibles, copayments and coinsurance work for most Members.

Example: Your health plan has a \$15 copayment, \$500 single deductible and 80/20 percent coinsurance with a \$1,000 coinsurance limit per benefit period. You visit a participating doctor who orders tests that are covered services and they cost \$750. Here's how it works:

Your copayment for the doctor visit: (copayment does not apply to deductible)	\$15
Charge for tests	\$750
Medical Mutual's negotiated rate for these services (Your costs are based on the negotiated rate.)	\$600
You must pay a \$500 single deductible (If you have covered dependents, you will have a family deductible.)	\$500
Balance remaining for tests	\$100
You must pay 20% coinsurance*	\$ 20
Medical Mutual pays 80% coinsurance	\$ 80
Your total out-of-pocket costs	\$535

*You have now paid \$20 toward your \$1,000 coinsurance limit. In some cases, coinsurance accumulates to a limit during your benefit period. Once you have met the limit, you will not have to pay any additional coinsurance amounts.

Coordination of Benefits

If you, your spouse or your dependent(s) are currently covered under another group health insurance plan in addition to your Medical Mutual plan, or become covered under an additional plan in the future, it is your responsibility to notify Medical Mutual of the other insurance information. You should contact Customer Service, or fill out and submit the Coordination of Benefits Response Form found under "Claim's Inquiry Response Forms" in the Members' section of our Web site, www.MedMutual.com. Coordination of Benefits (COB) with the other insurer is important in assuring correct processing of claims.

Submitting a Claim

Most SuperMed network and participating providers will submit a claim for covered services to Medical Mutual for you. However, if you choose to obtain a medical service from a physician or facility that is not in the SuperMed network or has not signed a participating agreement with Medical Mutual, please ask the provider if she/he will be submitting the claim on your behalf. If the provider will not be submitting your claim, then you will need to obtain a form from Medical Mutual to process your claim.

You may obtain a claim form by visiting *My Health Plan* or the Members' section of our Web site, www.MedMutual.com, by calling Customer Service or from your group administrator. Complete the claim form and send it, with a copy of the bill, to Medical Mutual at the address on your identification card. All claim forms must be received by Medical Mutual within 12 months from the date of service. Claims received after 12 months from the date of service will not be accepted. More information about how to submit claims or how claims are paid is found in your plan certificate.

Special Needs or Preferences

Medical Mutual recognizes that some Members have special needs or preferences, including speaking a primary language other than English or are visually or hearing impaired. If you have a special need relating to the administration of your health plan or obtaining medical services, please notify Medical Mutual by calling Customer Service, or TTY/TDD 1-800-982-8109 for the hearing and speech impaired. When Members who do not speak English call Customer Service, Medical Mutual will help you by connecting you to either an employee interpreter or a language line translation service. Medical Mutual will make every reasonable effort to meet your needs in a timely manner.

If you need to locate or prefer to see a provider who speaks a particular language or is able to address a special need or preference, please search in the network directory, on www.MedMutual.com or call Customer Service. You may also find a Spanish version and a large print version of this handbook in the Members' section of our Web site, or you may request a copy by calling Customer Service.

Filing a Complaint

If you have a complaint, please call, write or e-mail Customer Service at the telephone number or address listed on your identification card. You can e-mail Customer Service directly from *My Health Plan* on www.MedMutual.com. The Customer Service representative will either resolve your concern or send your concern to the most appropriate person or department. Quality-of-care issues, such as concerns about the appropriateness and

quality of healthcare services rendered by a physician or hospital, or appointment access problems, are addressed by our Clinical Quality Improvement department or committee. Your complaint will be resolved within 30 days of receipt, or sooner, depending upon the clinical urgency of the situation. After review by the department or committee, if you are not satisfied with the outcome, your complaint can be further pursued through the Member appeal process.

Filing a Member Appeal

You or your authorized representative may appeal an adverse benefit or claim decision within 180 days of the date you received the denial notice or letter. However, before filing an appeal, it is recommended to first call Customer Service if you need further explanation of your denied benefit or service. Customer Service may be able to resolve your issue over the phone. To file an appeal, you may call Customer Service, or send or fax a letter or Member Appeal form to:

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

The Member Appeal form can be found in the Members' section of www.MedMutual.com. The form can also be submitted electronically from this site. The appeal request must include the subscriber's and patient's full name, identification number, claim number if applicable, the reason for appeal, date of service and provider/facility name. Also include any supporting information or records, including photos, dental X-rays or radiology reports you would like considered in the appeal. If you choose someone else to represent you during the appeal process, please include with your appeal request a signed and dated statement authorizing that person to act on your behalf. Be sure to print clearly the person's name and telephone number. Dependents 18 years or older should have a signed authorization for parents to act on their behalf. A Power of Attorney (POA) form may be submitted, as applicable. Be sure to communicate with your providers to ensure that all pertinent medical information is submitted to the Member Appeals Unit within 180 days of the date that you received the denial notice or letter. Requests received after this time will not be accepted and your appeal will not be processed.

Types of Appeals

Urgent Care Claim Appeals:

Urgent care claim appeals are those claims or requests for medical care or treatment:

- Where withholding immediate treatment could seriously jeopardize the life or health of a patient or a patient's unborn child
- That could affect the ability of the patient to regain maximum function
- That, in the opinion of a physician, with knowledge of your medical condition, would cause you 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 Medical Mutual's receipt of the request. Call the precertification telephone number on your identification card for an urgent care claim appeal.

Pre-service Claim Appeals:

Pre-service claim appeals are those requested in advance of obtaining medical care for approval of a benefit, following the initial denial of a precertification or predetermination of a service.

Post-service Claim Appeals:

Post-service claim appeals are those requested for payment or reimbursement of the cost for medical care that has already been provided and payment denied.

Both pre-service and post-service claim appeals must be requested within 180 days of the date you received the initial notice of denial or letter. You will be notified in writing of the appeal decision within 30 days of Medical Mutual's receipt of the request. If the service is approved upon appeal and you have no financial liability, the claim will be adjusted and you will receive a new EOB.

You will receive a full and fair review of the claim by an appeals staff member, a physician consultant and/or other licensed healthcare professional who is in the same or similar specialty of the claim or service being appealed. All information submitted by you or the provider and obtained by Medical Mutual, without regard to whether such information was considered in the initial determination, will be considered during the appeal process. Your appeal will be reviewed by an individual who has not made any prior decision about your care and is not a subordinate of a healthcare professional who made a prior determination on your claim.

Prescription Drug Appeals:

Please note that if you have a prescription drug benefit, appeals for the medical necessity of a prescription drug will be handled by licensed pharmacists or physicians from Medco Health Solutions, Medical Mutual's Pharmacy Benefit Manager. Appeals for medical necessity of prescription drugs will follow a two-level appeal process. Each level will be decided within 15 days of Medco Health Solutions' receipt of your request for appeal. Urgent care appeals will be decided within 72 hours of receipt of your request. All other appeals, such as those related to eligibility or benefit coverage, should be submitted to Medical Mutual's Member Appeals Unit. You may submit your appeal for medical necessity of a prescription drug along with pertinent medical information to:

Medco Health
5151 Blazer Parkway, Suite B
Dublin, OH 43017
Phone 1-800-753-2581
Fax 1-800-711-5673

Levels of Appeal

Except as noted here, Medical Mutual offers all persons – fully insured, public employees and self-funded – one level of appeal followed by one level of voluntary appeal or review. The first level of appeal follows the initial denial of your claim, service or quality-of-care complaint decision. The first level of appeal is called a “mandatory level of appeal,” meaning that you must first proceed through Medical Mutual's internal appeal process before taking any further action with a group administrator, department of insurance or civil action. This one level of appeal is decided within 30 days of receipt of your request, except for urgent care claim appeals, which must be decided within 72 hours. You will be notified in writing by Medical Mutual of the appeal decision.

Please note that for some specific groups or Members, a mandatory two-level appeal process may be required, or a voluntary review by Medical Mutual may not be available. Please check your plan certificate/policy or with your group administrator for further details.

Following the one level of mandatory appeal, if your denial is upheld, you may have further options as described below. Options may vary depending upon the health plan you have and the state where your insurance certificate/policy was issued. These options will be given to you in writing at the conclusion of the first level internal appeal process. You should also refer to your plan certificate/policy if you need more information.

Voluntary Options

Independent External Review for Medically Necessary Services

Members who are fully insured through Medical Mutual, either by group coverage or non-group coverage, and Members of a Public Employee Benefit Plan may qualify for an independent external review according to state law following exhaustion of the internal appeal process. Independent external reviews for these Members are conducted by independent review organizations (IRO) approved by departments of insurance in the states where the policies were sold. As required by law, Medical Mutual will provide the IRO with copies of your records in order to conduct the review. Independent external reviews must be requested within 180 days from the date that you received the notice of denial letter on the first level mandatory appeal. To qualify for an independent external review, the benefit must be determined by Medical Mutual to be not medically necessary, and the service plus ancillary charges and follow-up care will cost you \$500 or more. If you have a terminal condition and are appealing treatment that is considered experimental or investigational, you are also eligible for an external review by a panel of physicians; the \$500 minimum liability does not apply in this case.

If the department of insurance determined that the healthcare service is not a covered benefit under your certificate/policy, if you have already had an external review for the same adverse decision and no new pertinent information was submitted, or if the total cost to you is less than \$500, then you are NOT entitled to an independent external review through the department of insurance by an IRO.

A request for an independent external review must be made in writing by the Member or authorized representative and addressed to the Member Appeals Unit at the address or fax number listed in this section. If a condition requires an urgent review, the review may be requested orally or electronically, with a written confirmation within five days. Contact the Care Management department precertification telephone number on your identification card for an urgent, independent external review. A written decision will be given within 30 days after submitting the request for an external review or three days for an urgent care external review, with a possibility of extending to five calendar days for good cause. Medical Mutual will provide coverage for services determined by the IRO to be medically necessary, subject to other terms, limitations and conditions of your plan certificate/policy.

Please contact Customer Service or your state's department of insurance for more information. You may find information on how to contact your state's department of insurance by going to the *Consumers'* section of www.naic.org, which is the Web site for the National Association of Insurance Commissioners.

Benefit Review by the Department of Insurance

Members who are fully insured through Medical Mutual, either by group coverage or non-group coverage, and Members of a Public Employee Benefit Plan may contact the department of insurance to request a review of benefits that were denied, reduced or terminated.

Voluntary Review by Medical Mutual

If you have exhausted your first level of mandatory appeal and Medical Mutual has notified you that your request for services or claim payment is still denied because Medical Mutual has determined it is not medically necessary or not a covered benefit, you are eligible for an additional level of appeal if you meet the criteria listed below. This additional review is voluntary. If you choose a voluntary review, it will not affect your benefits according to your plan certificate/policy or group contract. If you are a member of an Employee Retirement Income Security Act (ERISA) plan, you are not required to exhaust a voluntary review if you also choose to pursue civil action. **To request this additional review, you must contact the Member Appeals Unit within 60 days of receiving the decision on your first level of appeal.** Follow the same procedures as described for filing a Member Appeal. Submit a copy of your previous denial letter along with any additional information, and state why you think the claim denial should be overturned. The voluntary review will be conducted within 30 days of receipt by Medical Mutual. To qualify for the voluntary review, the following must apply.

- You are fully insured through Medical Mutual, either by group coverage or non-group coverage, or you are a Member of a Public Employee Benefit Plan, but you are *not* eligible for an independent external review through the department of insurance for a medical necessity determination because the denied service(s) will cost you *less* than \$500.
- You are a Member of a self-funded group whereby the department of insurance does not have jurisdiction, and your group does not require you to use an alternative dispute resolution procedure.

Voluntary reviews for medical necessity determinations will be conducted in the same manner as the first level of appeal. A physician consultant or licensed healthcare professional, who did not make any prior decisions about your care and who is not a subordinate of any prior reviewers, will make the determination for medical necessity on this voluntary review.

If the last decision is to uphold the denial as previously determined by Medical Mutual, you should check your plan certificate/policy for further information or options.

ERISA Plans:

For members of an ERISA plan, the group administrator is required to administer the plan in accordance with its written provisions. Members of an ERISA plan also have the right, under Section 502(a) of ERISA, to bring a civil action after a denial on appeal. Please contact your group administrator for more information. Any statute of limitations applicable to pursuing your claim in court will be tolled or suspended during the period of the voluntary appeal process.

If you are a member of an ERISA plan and you have elected to proceed with a voluntary review as described in this section, you do not need to exhaust the voluntary option prior to pursuing a claim in court.

Further Information

Member appeals – mandatory and voluntary, independent external reviews and benefit reviews by the department of insurance – are conducted at no charge to the Member or provider. Upon written request, and free of charge, you may ask for reasonable access to, and copies of, documents, records and other information used to decide the appeal; the benefit provision, guideline or protocol on which the decision was based; further explanation that details the scientific or clinical criteria that formed the decision; or for qualifications of the reviewer. For further information on your member appeal, send your request in detail to the Member Appeals Unit or the address listed on your letter.

Points to Remember If You Choose to Appeal:

AS APPLICABLE TO YOUR HEALTH PLAN:

- Before filing an appeal, first contact Customer Service if you need further explanation of your denied benefit or service.
- File your appeal for a first level review *within 180 days from receiving your initial notice of denial, reduction or termination of payment or service.*
- File your request for a voluntary second review *within 60 days after receiving notice of a denied first level appeal.*
- File your request for an independent external review through the department of insurance *within 180 days after receiving notice of a denied first level appeal.*
- For your convenience, file a member appeal by going to the *My Health Plan* section of our Web site, *www.MedMutual.com*, and obtaining an appeal form. You may file your appeal by mail, by fax or electronically. When submitting a request for an appeal, please be sure that all applicable records, X-rays and photos are promptly sent to Medical Mutual's Member Appeals Unit.

- Always check your plan certificate/policy or with your group administrator for more information and the specific terms of your contract.
- Go to the *Consumers'* section of the National Association of Insurance Commissioner's Web site, www.naic.org, to find out how to contact your state's department of insurance.
- You or your provider must submit your initial claim for payment to Medical Mutual within 12 months from the date of service.

Member Satisfaction

Your satisfaction is very important to us. Maintaining high levels of Member satisfaction is a primary goal of Medical Mutual's comprehensive Quality Improvement (QI) Program, which strives to improve the quality of medical care and service offered to our Members and providers. Conducting periodic satisfaction surveys, analyzing Member complaints and appeals, and monitoring our telephone services are several of the quality improvement activities that we routinely perform to help us achieve our goal of continually improving your satisfaction. Surveys are conducted either by Medical Mutual or by a survey company on behalf of Medical Mutual. If you receive a survey form or a phone call, we respectfully request that you complete the survey so that we may continually address your needs through our quality improvement plan. A complete description of the QI Program and the QI Program Evaluation is available to any Member upon written request. Send your request to:

The Clinical Quality Improvement Department
Medical Mutual
MZ: 01-5B-7501
2060 East Ninth Street
Cleveland, OH 44115-1355

Notes:

Notes:



MEDICAL MUTUAL™
Your healthcare partner since 1934

2060 East Ninth Street
Cleveland, Ohio 44115-1355
TTY/TDD 1-800-982-8109

www.MedMutual.com

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