MEDICAL MUTUAL®
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Member Guide

Frequently Asked Questions



MEDICAL MUTUAL®

Get the Most Out of Your Health Insurance Benefits

Use these tips to understand your care options, maximize your benefits and save money:

- **Manage Your Plan 24/7:** My Health Plan, our members-only website, makes it easy and convenient to manage your plan. Search for in-network doctors, access your member ID card, view benefits, and more. Members may register or log in at MedMutual.com/Member.
- **Stay in Network:** Avoid higher costs by using doctors and hospitals in your plan's network. Use our MedMutual Find a Provider tool on My Health Plan to find in-network providers. Or download our MedMutual mobile app from your favorite app store.
- **Know What's Covered:** Review your benefits online or talk with a Customer Care specialist before you receive care to make sure a service is covered or find out if prior approval is needed.
- **Avoid Unnecessary Trips to the Emergency Room:** For minor injuries or illnesses, visit your primary care provider (PCP) or use an in-network convenience clinic or urgent care facility.
- **Make Health and Wellness a Priority:** Taking care of your body and mind can help you prevent illness, reduce risk of chronic conditions, and live a happier and healthier life. Visit our Wellness Portal under the Healthy Living tab on My Health Plan for a variety of tools, resources and wellness challenges to help you be your healthiest self.
- **Use Your Preventive Care Benefits:** Take advantage of preventive services and programs covered at little or no cost to you. Review your benefits online or call Customer Care for more information.

If you do not have access to the internet or prefer to have information explained or provided in a written format, contact our Customer Care specialists at the number on your member ID card.

Our products are underwritten by Medical Mutual of Ohio or Medical Health Insuring Corporation of Ohio.

The material provided, including websites and links, is informational only. It does not take the place of professional medical advice, diagnosis or treatment. You should make decisions about care with your healthcare providers. Recommended treatment or services may not be covered. Eligibility and coverage depend on your specific benefit plan.

Welcome to the Family

Medical Mutual® is committed to helping our members get the care they need by providing access to high-quality healthcare, a large network of doctors and hospitals, and a wide range of health programs designed to help them live healthier through all stages of life.

We've created this Member Guide to help you understand how to get the most out of your health plan benefits.

If you are a current Medical Mutual member, visit My Health Plan, our secure member website, at MedMutual.com/Member, for more information. Or call Medical Mutual Customer Care at the number on your member ID card. Information about your specific plan benefits can also be found in your Certificate or Benefit Book.

If you are not a current member, additional resources and information are available online at MedMutual.com.

We look forward to serving your healthcare needs.

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What charges do I need to pay for when I receive services?

Depending on your plan, you may be responsible for:

- A copay at each visit
- An annual individual and/or family deductible
- Coinsurance up to your maximum out-of-pocket amount
- Charges for non-covered services
- Charges in excess of the allowed amount if you go to a doctor or facility not in our network
- Charges in excess of a coverage maximum, if applicable to your plan

For specific details about the charges you will need to pay, refer to your Certificate or Benefit Book, Summary of Benefits and Coverage (SBC) or other documentation provided by your employer or broker.

How do I know if my plan covers a certain procedure, surgery or service?

To check your covered benefits, review the Schedule of Benefits section in your Certificate or Benefit Book, or your Summary of Benefits and Coverage (SBC). These documents may also be available when you log in to your plan's website or My Health Plan. Call our Customer Care specialists if your specific service is not listed in the Schedule of Benefits or Exclusions.

Covered benefits usually include medically necessary hospital stays and surgeries, diagnostic tests, visits to the doctor and preventive care. Some plans include prescription drug coverage.

Medically necessary (or medical necessity) means the services, supplies or prescription drugs are needed to diagnose or treat a medical condition. Also, Medical Mutual must decide if this care is:

- Accepted as standard practice. It can't be experimental or investigational.
- Not just for your convenience or the provider's convenience.
- The appropriate type of service in the most appropriate setting that it can be provided to you.

When applied to your care as an inpatient, this means 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 other prescription drugs that will produce similar clinical results.

Excluded services typically are convenience or personal hygiene items, massage therapy, hypnosis, most over-the-counter drugs, vitamins or herbal remedies, experimental or investigational treatments, charges for missed appointments, or cosmetic procedures. Be sure to review your Certificate or Benefit Book, which may also be available when you log in to your plan's website or My Health Plan, for a full list of coverage exclusions.

Note: The most accurate way to get specific benefit details for a particular procedure or service is to call Customer Care and provide the medical coding your doctor's office will use on the claim. This includes codes for the specific service provided (the CPT codes) and the reason for the service (the diagnosis codes).

How does Medical Mutual determine if a new medical technology or procedure is covered?

We perform an extensive evaluation of the use of new medical technologies, medications, behavioral health procedures and devices to ensure they are medically appropriate for our members. After multiple experts (both internal and external, depending on the complexity of the issue) conduct this evaluation, a decision is made whether to cover the new service for our members. Coverage for new services may be limited to specific medical conditions, age groups, gender, places of service, types of service or diagnoses. Experimental or investigational services may not be covered. A list of services requiring prior approval (also called prior authorization) can be found on My Health Plan by clicking on Prior Approval under Benefits & Coverage or by calling Customer Care.

Where can I find a list of doctors, hospitals or providers who are in my plan's network?

To find a list of network providers:

- Log in to My Health Plan and select Find a Provider.
- Search MedMutual in your favorite app store to download our mobile app..
- Call our Customer Care specialists at the number on your member ID card.

If you are not a member, visit MedMutual.com and choose Find a Provider at the top of the page to see what networks and providers are available to you.

What happens if I don't go to doctors or health providers in my plan's network?

Using doctors, specialists, hospitals and other facilities (e.g. labs, urgent care clinics, radiology) in your plan's network can save you money. Using providers outside your network may cost you more. The name of your provider network and plan type (PPO, HMO, EPO) can be found on your member ID card.

- If you have a PPO plan and go outside the network, you will be responsible for paying a non-network deductible and coinsurance, and/or excess charges above the allowed amount we would normally pay for covered services. However, you may be afforded certain protections in emergency situations or if an in-network provider is unavailable. See information below about the No Surprises Act.
- If you are a member of an HMO or EPO plan, or a health plan with a narrow or local network, you do not have out-of-network coverage except for emergency services. You will be responsible for paying 100% of out-of-network charges. However, you may be afforded certain protections in emergency situations or if an in-network provider is unavailable. See information below about the No Surprises Act.

No Surprises Act

For members with plan years beginning on or after Jan. 1, 2022, the No Surprises Act allows members protection from balance billing (also known as surprise billing), only requiring them to pay the in-network billing amount under the following circumstances:

- Emergency care from in-network or out-of-network providers
- Non-emergency care from out-of-network providers at in-network facilities (e.g. anesthesiology, pathology, radiology)
- Air ambulance service(s) from out-of-network providers

The No Surprises Act does not apply when a member voluntarily chooses to use an out-of-network provider, receives notice, and signs a consent form to be billed for such services.

> **For additional benefit questions, call Customer Care at the number on your member ID card.**

How do I get primary care services?

Primary care services, like immunizations and physical exams, are done by providers who specialize in general medicine, family practice, internal medicine, geriatrics and pediatrics. These services are often provided in your primary care provider's office. While Medical Mutual does not require members to have a primary care provider (PCP), establishing a relationship with a PCP can offer you consistency and efficiency in your health care.

To find a PCP in your plan's network, log in to My Health Plan and choose Find a Provider.

Not Our Member? Learn More.

Here's how to get more information about Medical Mutual's covered and non-covered services, network options and benefit restrictions:

- If you are looking for an individual policy, review plans available in your area on MedMutual.com (sample Certificate Books are also available).
- If you are part of an employer group plan, review the SBC provided as part of your open enrollment materials.

Visit MedMutual.com and choose Find a Provider at the top of the page to see the networks and providers that may be available to you as our member.

How can I find information about network doctors, hospitals and other providers?

Find information about providers in your health plan's network by using the Find a Provider tool on My Health Plan, or in the MedMutual mobile app. Provider types include doctors, therapists and counselors, hospitals, urgent care centers, durable medical equipment suppliers, and more. Information includes:

- Name, address and phone number
- Professional qualifications
- Specialties
- If the provider is accepting new patients
- Medical school attended
- Hospital and network affiliation
- Board certification
- Awards and recognition, such as whether a doctor is part of an NCQA accredited patient-centered medical center or diabetes recognition program
- Quality scores

If you are not yet our member, similar information can be found at MedMutual.com/FindAProvider.

How do I get behavioral health, specialty or hospital services?

To request behavioral health services, contact a behavioral health provider, counselor or addiction specialist, in your plan's network. Information about network specialists can be found by using Find a Provider on My Health Plan or in the MedMutual mobile app. Your primary care provider (PCP) can tell you when and where to get behavioral health, specialty and hospital services. Check your Certificate or Benefit Book for coverage of mental health disorders and substance abuse.

How do I find a palliative or hospice care provider?

Palliative care is treatment that enhances comfort and improves the quality of a person's life during the last phase of life. We urge you to discuss this matter with your provider and family.

To find a network palliative or hospice care provider, log in to My Health Plan at MedMutual.com/Member or on our mobile app. Choose Find a Provider and search for physician or facility using the keyword Hospice.

What should I do if I have trouble scheduling an appointment?

We want you to be satisfied with the care you receive. If you have trouble scheduling an appointment with a medical or behavioral healthcare professional, please contact Customer Care by phone or on My Health Plan.

How can I get care after normal office hours?

When you are ill, injured or need care, call your primary care provider (PCP) first. Your PCP can assess your symptoms and direct you to the right place for care. If your PCP's office is closed and you need prompt, but non-emergency, medical attention, go to a network urgent care facility or convenience clinic that can treat your condition. This may cost less than an emergency room visit. You can find a network urgent care facility by using our Find a Provider tool. Choose Urgent Care Center as the facility type.

Conditions that an urgent care or convenience clinic may treat include:

- Flu symptoms
- Minor sprains
- Sinus, ear or bladder infections

Your health plan may also offer a 24-hour Nurse Line service for help with non-emergency situations. You'll find the phone number on your member ID card if the program is available to you.

What is an emergency?

Recognizing emergency situations can be difficult for a person with no medical training. Seek emergency care if you believe not receiving immediate assistance would result in the following outcomes:

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

Details about your specific benefits plan can be found on My Health Plan.

Everything You Need, Everywhere You Are

My Health Plan is the quick, easy and secure way to take care of all your health plan needs, 24/7. You can access the site online or by downloading our mobile app.

Visit MedMutual.com/Member to:

- See real-time account information, like deductible, coinsurance and maximum out-of-pocket accumulations.
- View and download plan documents, such as your Certificate or Benefit Book and Summary of Benefits and Coverage (SBC).
- Update your profile information, such as your primary care provider (PCP).
- Estimate costs for many healthcare services and procedures.
- Access money-saving discounts or enroll in programs and services, such as WeightWatchers® and our tobacco cessation program.
- Manage your communication preferences, opt in for text messaging and go paperless for other options.

Search MedMutual in your favorite app store to download our mobile app to:

- Access and email or fax your digital ID card to your providers.
- Find a doctor, hospital or urgent care facility based on your location.
- View your claims, deductible and out-of-pocket spending information.

Medical Mutual members can register for My Health Plan at MedMutual.com/Member.

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How do I get emergency care?

During a medical emergency, go to the nearest emergency room or, if necessary, call 911. Contact your network provider within 24 hours of the emergency to arrange follow-up care, if necessary. You should see your provider within seven days of an emergency room visit, within seven days for an inpatient stay for behavioral health services or within 30 days of an inpatient stay for other services. If you are admitted to a hospital, our Care Management department will work with your provider to review your care. You do not need to contact Medical Mutual for prior approval of emergency care.

Do I need prior approval for certain procedures?

Yes. Certain services and drugs require prior approval before you have the procedure or service—especially if the service or drug is considered experimental or investigational and not eligible for coverage. Your in-network provider is responsible for getting any required prior approvals. Prior approval is not a guarantee of payment; payment is based on your benefits and contract provisions. Visit My Health Plan and click on Prior Approval under Benefits & Coverage to view the services and medications on the Prior Approval List.

How do I get prior approval?

If your provider is in your plan's network, they will be responsible for contacting us for prior approval. If your provider is not in the network, you will be responsible for getting prior approval before treatment. Contact Customer Care if you need help requesting prior approval. If you are scheduled for a hospital stay, our nurses will work with your provider to gather information about your condition once you have been admitted to the hospital.

Medical Mutual sends an appropriate care statement to all employees, management staff and contracted providers who deal with these activities.

If you have questions related to inpatient admissions, denials and appeals, including those for behavioral health services, you may call the appropriate number below. Or call Customer Care at the number on your member ID card.

Care Management	1-800-338-4114
Behavioral Health Care Management	1-800-258-3186
Case Management	1-800-258-3175
TTY/TDD for the Hearing and Speech Impaired	1-800-750-0750 or speed dial 711

Decisions are based only on the appropriate use of care and services for you and your coverage. There isn't any direct or indirect reward or incentive for providers or any other participants in decision making for denying or limiting coverage or service. We don't provide financial incentives for decisions that result in less use of care or services.

Manage and Improve Your Health

Visit our Wellness Portal on My Health Plan to learn about programs and tools to help you maintain or improve your health and well-being. Complete our short, online Health Assessment to identify your risks for certain chronic diseases. You will also get tips and information to help manage and improve your health. To track changes in your health status, we recommend you complete the Health Assessment once a year.

You'll also find articles, healthy recipes, fitness challenges and online classes on a variety of health and wellness topics.

Find the Wellness Portal under the Healthy Living tab on MedMutual.com/Member.

Can I get help if I have a chronic condition?

Yes. Medical Mutual offers a variety of flexible programs to help members with chronic conditions, such as diabetes, hypertension, asthma, and more. These programs, which include digital or telephonic options, can help you understand your condition, become more involved in your care, make healthy lifestyle changes and improve your quality of life.

We also offer coaching programs on topics such as weight management and stress reduction to help you improve your health and wellness.

To learn more about these programs, log in to My Health Plan and click the Healthy Living tab.

How can I or my caregiver get help if I have a complex medical condition or event?

Registered nurse case managers in our Case Management program are available to help you or your caregiver find resources and services, communicate with your healthcare team and monitor your progress to make sure services are appropriate and effective. This voluntary program addresses the healthcare options and needs of members who have complex illnesses or life-limiting or incurable conditions, such as cancer, heart disease, chronic kidney disease, transplants and many more.

Case Management nurses are also available to help coordinate care, offer information about local community services and provide education about your condition.

You can talk with a registered nurse case manager Monday through Friday from 8 a.m. to 5 p.m. (ET). You'll find their number in the chart on page 7.

How do I get care and coverage when I am away from home?

If you get sick or are in an accident while away from home, use our Find a Provider tool on My Health Plan or our mobile app, or call Customer Care, for help finding a network doctor or hospital. If your condition is a medical emergency, go to the nearest emergency room or, if necessary, call 911.

If you are a member of an HMO plan or EPO plan, you only have out-of-network coverage for emergency services. You will be responsible for paying all non-emergency out-of-network charges in full.

What is an advance directive (e.g., Living Will, Power of Attorney, Do Not Resuscitate)?

An advance directive is a legal document used to tell doctors, hospital personnel, your family or your representative what kind of care you want to receive if you become unconscious or unable to communicate. There are three types of advance directives: Living Will, Healthcare Power of Attorney and Do Not Resuscitate (DNR) order. For more information about setting up an advance directive, contact the National Alliance for Care at Home at allianceforcareathome.org or nhpco.org.

Where do I find a claim form and how do I submit a claim?

In-network providers must submit a claim for you. If you go to a doctor, hospital or provider that is not in your plan's network, ask them to submit a claim for you on a standardized claim form.

To find claim forms:

- Visit MedMutual.com and choose Member Forms at the bottom of the page.
- Log in to My Health Plan. Next, choose Resources & Tools, then Forms.
- Call Customer Care at the number on your ID card.

If the provider will not submit the claim for you, contact Customer Care or log in to My Health Plan for a claim form. You will need to complete the claim form and attach an itemized bill that includes the patient's first and last name, diagnosis, procedure, date of service, a breakdown of charges and the name and address of the provider or facility. Submit the completed form to the address on the form within the timeframe stated in your Certificate or Benefit Book.

If you go to a hospital or provider outside the United States, get a copy of all your medical records and an itemized bill. Submit your claim forms, bills, medical records and proof of payment to the address on your ID card. Please remember, benefit coverage and limitations still apply when you are traveling. Refer to your Certificate or Benefit Book for details.

How can I ask a question or voice a complaint?

We want to make sure our members are satisfied with the care and service they receive. If you have a problem or concern, you can:

- Call Customer Care.
- Email Customer Care through My Health Plan by clicking on Contact Us.
- Mail a letter to your benefit administrator or employer, or to Medical Mutual, 100 American Road, Cleveland, OH 44144.

We will follow the complaint review procedure described in your Certificate or Benefit Book.

Can I file a complaint anywhere else?

If applicable to your health plan, you may contact your state's department of insurance (DOI). You can find the contact information on your state's website, under state agencies in your phone book or by calling our Customer Care Team. If your complaint is about a denial, reduction or termination of a benefit or service, and you continue to disagree with our decision, you have the right to file a complaint with the DOI after all appeal rights have been exhausted.

In general, members of self-funded groups (other than a public employee benefit plan) should not file a complaint with the DOI. To learn how to file a complaint, contact your group official or employer, check your Certificate or Benefit Book, or contact the U.S. Department of Labor Employee Benefits Security Administration (dol.gov/ebsa).

How can I file an appeal if my claims, requested services or eligibility have been denied?

- If you are part of a self-funded group, refer to your Benefit Book for how to file an appeal.
- All other members may refer to the following appeal procedure.

As a member, you may exercise your right to appeal a denial to pay a claim or approve a service or procedure according to applicable state and federal law. There is no charge for filing an appeal.

You must file your appeal within 180 days from the date you received your original denial. Member appeal forms can be found under Forms in the Resources & Tools section of My Health Plan or by calling Customer Care. Instructions for completing the form and submitting your appeal are included on the form. To support your appeal, please send any records, doctor's office notes, photos, dental X-rays and/or radiology reports you would like considered.

An appeal request must come from the patient unless they are a minor (in which case a parent or legal guardian of the patient may file the appeal), have appointed an individual as power of attorney representing the patient, or have authorized an individual to act as their representative.

To appeal a denial for services you need immediately, call Care Management or Behavioral Health (see page 7). Urgent care appeals will be decided within 72 hours, as will appeals for care you need while you are in the hospital (or sooner if required by applicable law). Our decision about all non-urgent appeals will be made within 30 days from the date we receive your appeal request (or sooner if required by applicable law). You will receive our decision in writing. If our original decision is not overturned, you will be notified of any additional appeal rights you may have.

Could the department of insurance (DOI) review my case if it is denied?

Depending on the type of health plan you have and the reason that payment of a claim or approval of a service or procedure was denied, DOI review of the case might be available. You should first file your appeal with us. If your appeal has been reviewed and continues to be denied, you or an authorized representative (an individual authorized by you to file appeals on your behalf) will be informed of any additional appeal rights, including instructions for how and where to file your request for review by your state's DOI, if such a review is available.

How can I get an independent external review of my denied claim or request for a service or procedure at no cost?

Depending on your health plan, you may qualify for an external review by an Independent Review Organization (IRO) if the service you are appealing meets certain conditions set by applicable state or federal law. You must first exhaust the internal appeal process with Medical Mutual unless you are eligible to exercise our external review rights concurrently or immediately. You will be told in writing of your external review rights as part of our initial appeal decision. You will also be told of the timeframe you have from the date you receive our initial appeal decision to request an external review. IROs will decide urgent and non-urgent cases in the timeframes established by the applicable state or federal laws and regulations. You will be told in writing of the IRO's decision.

What are my appeal rights?

For members of an Employee Retirement Income Security Act (ERISA) plan, the group administrator is required to administer the plan according to 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 to learn if you are affected by ERISA or for more information. Any statute of limitations applicable to pursuing your claim in court will be suspended during the period of the additional voluntary appeal (if your plan includes a voluntary appeal). If you decide to proceed with a voluntary appeal (if your plan includes a voluntary appeal), you do not need to exhaust this option prior to pursuing a claim in court.

If you are an individual policyholder, your plan is not subject to ERISA, so your rights are different from those available to an ERISA plan member. Please refer to your Benefit Book for more information.

If you are a member of a health plan sponsored by a public entity (e.g., public schools, governments), your plan is also not subject to ERISA. Please refer to your Benefit Book for more information about your appeal rights.

How does Medical Mutual improve the quality of healthcare?

We continually work to promote and improve the quality of healthcare for members through our Quality Improvement program, which supports our mission to provide clinical excellence at a reasonable cost and to improve patient outcomes. Our goals are to:

- Improve the quality and safety of healthcare services for members and their access to those services.
- Communicate clinical information to members and providers.
- Monitor and evaluate the quality and safety of healthcare provided to members.
- Achieve and maintain health plan accreditation.

At times, Medical Mutual conducts member surveys—for example, about your satisfaction with your health plan. We appreciate receiving completed responses, which help us improve our services.

How should my child's care change when they turn 18?

At age 18, children are considered adults when it comes to healthcare. If your child has not already done so, encourage them to transition from pediatric care to a doctor or other healthcare provider who specializes in adult care. Completing this transition helps ensure the appropriate care is given in the appropriate setting based on your dependent's changing needs. Age-appropriate services include new vaccines and boosters as well as important preventive screenings.

Once a member turns 18, they should create their own My Health Plan account at MedMutual.com/Member. They can then use the Find a Provider tool to find an adult primary care provider (PCP). Our Customer Care teams are also available to help.

The MedMutual mobile app makes it easy to access your benefits information while on the go.

Member Rights

What are my rights and responsibilities as a member?

As a Medical Mutual member, you have certain rights and responsibilities. Being familiar with them will help you participate in your own healthcare, which will ultimately empower you to make the best healthcare decisions possible.

Please know we support member rights and member responsibilities, which we define as your role in working with us to achieve a high-quality, cost-effective health outcome. We encourage you to review these guidelines to be an informed healthcare consumer.

For a printed copy of our Member Rights and Responsibilities, please call our Customer Care Team at the number on your ID card. This document is also available on our website, MedMutual.com/MemberRights.

Information Disclosure

- You have the right to receive accurate, easy-to-understand information about your health plan, providers, covered services, financial liability, health promotion, illness prevention, advance directives (e.g., Living Will, Healthcare Power of Attorney), and rights and responsibilities.
- You have the right to receive information about us. As applicable to your plan, you have the right to receive information about services provided on behalf of your employer or plan sponsor as well as our staff, and staff qualifications and any contractual relationships.
- You may choose to ask another person to help you or act on your behalf if you are unable to act alone at any step in the healthcare process.
- If English is not your primary language or if you have a disability or do not understand your health plan or healthcare, we can provide help so you can make informed healthcare decisions.

Access to Emergency Services

- If you have severe pain, an injury or sudden illness that leads you to believe that your health is in serious jeopardy, you have the right to be screened and stabilized for an emergency medical condition in a facility that provides emergency care.
- When you are injured, or experiencing severe pain or sudden illness that leads you to believe your health is in serious jeopardy, you do not need our prior approval before seeking emergency care.
  - When using emergency room services for emergency care, you are not required to see a network provider, and you will not be charged an out-of-network penalty for receiving services for emergency care from an out-of-network provider.

Choice of Providers

- You have the right to choose providers, hospitals, pharmacies and other facilities within our network.
- You have the right to choose a primary care provider (PCP) in our network who is accepting new patients.
- You have the right to see a specialist in our network without a referral from your primary care provider (PCP).

Coverage

- If you are a member of a group health plan or non-grandfathered individual policy, with plan years beginning on or after January 1, 2014, you have the right to receive covered services without the consideration of pre-existing conditions.
- You have the right to not have your policy rescinded after it was active except in situations of fraud or intentional misrepresentation, according to federal and state laws and the terms of your policy.
- You may have the right to receive certain essential health benefits covered by your health plan without annual dollar limits.
- You have the right to get covered services and prescriptions filled within a reasonable timeframe.
- You have the right to receive coverage for an ongoing course of treatment pending the outcome of an appeal of a coverage decision that reduces or terminates benefits for that course of treatment.
- For the services provided to you within the terms of your plan, your rights include prompt and accurate payment of your claims.
- You have the right to have your coverage decisions made by individuals who have expertise in the area of medicine in which your claim falls and by individuals who are impartial.

Participation in Your Health Plan and in Treatment Decisions

- You have the right to talk in confidence with your healthcare provider and to participate in making decisions about your care.
- You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- You have the right to decline medical treatment or participation in a program we offer and to disenroll from services we offer.
- You have the right to make recommendations about our Member Rights and Responsibilities policy statement.
- You have the right to restrict the information that your healthcare provider shares with your health plan if you self-pay for services in full and notify the provider of your restriction.

Privacy and Confidentiality

- You have the right to exercise all federal and state privileges that protect your personal and medical information and records. You can also exercise your privacy rights under the Health Information Portability and Accountability Act (HIPAA) without fear of retaliation or condition of payment.
- You have the right to privacy and confidentiality in the usage of your personal and medical information and records.

Respect and Nondiscrimination

- You have the right to fair, considerate, courteous, respectful and nondiscriminatory care from your healthcare providers, our employees and plan representatives. You have the right to be treated with respect and recognition of your dignity and your right to privacy.
- You have the right to ask for help if you think you are treated unfairly or your rights are not respected.
- You are not required to waive rights to get benefits from your health plan.

Request to Place Restrictions on Use/ Disclosure of Protected Health Information

- You have the right to request that your information receive special treatment, meaning that you can request additional restrictions on your information when used for treatment, payment or other day-to-day operations. Please Note: Medical Mutual of Ohio is not required to agree to the restriction.
- You have the right to access or receive a copy of your protected health information (PHI) maintained by us in a designated record set. For access to your entire medical record, you must contact the doctor or facility that provided the service.
- You have the right to request an amendment to your personal and medical information. We cannot amend information we did not create. We will refer you to the service provider if you request an amendment to your diagnosis or treatment information.
- You have a right to an accounting of certain disclosures of your information made by us and our business associates over the last six years.
- You have the right to complain if you believe your rights have been violated, including the right to complain to the Secretary of the U.S. Department of Health and Human Services.
- You have the right to receive a Notice of Privacy Practices describing our legal duties and privacy practices with respect to your PHI.
- You have the right to request that we communicate with you in confidence about your information at a location different from the address associated with your policy.

Complaints and Appeals

- You have the right to voice complaints or appeals about us, the care provided or any quality issue.
- You have a right to communicate complaints to us and receive instructions on how to use the complaint process that includes our standards of timeliness for responding to and resolving complaints and quality issues.
- You have the right to request and receive, at no charge, copies of the information and documentation we considered or relied on to make a coverage decision.
- You have the right to file an appeal of a denial or reduction of a benefit or a claim because you were told it was not medically necessary, was experimental or investigational, was not a benefit of your health plan or involved a pre-existing condition.
- You have the right to file an appeal if you were denied coverage because of ineligibility or your policy was rescinded after you became an active member.
- You have the right to get a fair, objective and timely review and resolution of an appeal; to be told how the appeal will be handled according to federal and state laws; and to be told any important time limits related to filing your appeal.
- If you are covered by a fully insured plan, you have the right to request a review of a denied service or benefit by your state's department of insurance (DOI). A review by your state's DOI may be available if we deny, reduce or discontinue coverage for a service you were told is not covered, not medically necessary or is experimental or investigational.

- Once you have exhausted your internal appeals, you may have the right to an external review by an Independent Review Organization (IRO). This right may exist if we deny, reduce or discontinue coverage for a service on the basis of medical necessity, appropriateness of care, healthcare setting, level of care, effectiveness of a covered benefit, or an experimental or investigational determination. This right depends on the type of health plan you have. Review your Certificate or Benefit Book, or contact us or your health plan administrator to find out if this right and the process for pursuing this right applies to your health plan.

Member Responsibilities

- When speaking with us or your provider, supply all the information needed to provide care.
- When speaking with us or your provider, understand your health problems and participate in developing a mutually agreed-upon treatment plan and goals that work for you and your doctor or health provider, to the degree possible.
- When speaking with us or your provider, follow the agreed-upon plan and instructions for care.
- Choose a primary care provider who is accepting new patients and can coordinate medical services if required or advised by your plan.
- Take responsibility for improving or maintaining your healthy lifestyle habits including exercising, not smoking, controlling stress, eating a healthy diet, drinking alcohol only in moderation and following safety guidelines.
- Learn how to voice a complaint and file an appeal.
- Learn about your coverage options, limitations and exclusions by reviewing the resources available to you.
- Know the rules about use of network providers, coverage and prior approval according to your plan.
- Know how to get information from your health plan's website, customer service and/or your health plan administrator.
- Meet your financial obligations to the providers who treat you.
- Report to us suspected wrongdoing and fraud.
- Be a responsible consumer of healthcare resources available to you.

Is support offered for language or speech assistance?

Yes, we provide language assistance for those who speak a language other than English or have special needs related to impaired vision or hearing. If you have a special preference relating to the administration of your health insurance plan or getting medical care, please call Customer Care (or TTY/TDD 1-800-750-0750 or speed dial 711 for the hearing and speech impaired). If you need large-print materials, please call Customer Care.

Language assistance is available to answer your questions and help you register an appeal or complaint. We offer bilingual telephone translation services and can respond to your appeal or complaint in your primary language. To ask for language assistance, please call Customer Care and tell the Customer Care specialist that language assistance is needed.

Callers who do not speak English will be connected by Customer Care to a language line interpretation service.

What does Medical Mutual do to protect my right to privacy?

We have strict policies and procedures to protect your personal information, including your health information that is stored on our computer systems and in our files. You can view our Notice of Privacy Practices on our website for more information on the collection, use and disclosure of members' protected health information (PHI), and how to access, amend or request a restriction to the use or disclosure of your PHI by Medical Mutual. Visit MedMutual.com and look for the HIPAA Privacy link in the footer, or call Customer Care.

How do I change my contact information?

You can change your contact (e.g., address, phone number, email, primary care provider) by logging in to My Health Plan at MedMutual.com/Member. Click on My Profile, then Profile Settings to review and make changes. You can also call Customer Care to make any necessary changes.

If you have coverage through a group health plan, it may be necessary for you to contact your plan sponsor in order to make the needed updates.

How can I update family members on my plan?

If you have coverage through your employer, work with your employer to add or remove dependents. If you have individual or family coverage through a broker, work with your broker to add or remove dependents. If you have individual coverage that you bought directly from Medical Mutual without a broker, or need assistance, please contact Customer Care.

Prescription Coverage

What procedures should I follow to fill prescription drugs?

1. Use a network pharmacy. Existing members should log in to My Health Plan at MedMutual.com/Rx and click Sign on to Express Scripts. On the Express Scripts website, select Find a Pharmacy under the Prescriptions menu to locate nearby pharmacies by ZIP code and identify preferred network pharmacies (if available). Or call the Rx Information number on your member ID card.

   If you are not yet a member but would like to understand what pharmacies are in our current network, visit providersearch.medmutual.com and select your plan type. Select the option that applies to you to be redirected to the pharmacy search tool.

2. Present your member ID card to your pharmacist to ensure your benefits are being used.

3. Choose drugs on your plan's formulary. The formulary contains a wide selection of brand-name and generic medications that could help lower your costs. To see drugs covered by your plan and any associated deductibles, copayments, and out-of-pocket costs, current members log in to My Health Plan at MedMutual.com/Rx and click on the Sign on to Express Scripts button. From the Express Scripts website, select Prescriptions and then Price a Medication. For an overview of our prescription drug benefits, select Benefits and then Benefits Overview. Or call the Rx Information number on your ID card.

   Some medications may have limitations or other requirements that must be met prior to coverage being provided. This is discussed under the topic "Are there any limitations on the medications my doctor might order?"

If you are not yet a Medical Mutual member, you can find information about our available formularies and any associated restrictions or limitations on MedMutual.com. For Individual & Family plans, select Individuals and Families from the Insurance Plans tab, then select Medical under Plans and Products and scroll to the Prescription Drug Coverage section. For coverage through your employer, select Employers from the Insurance Plans menu and choose Prescription Drug Information under the Employer Resources section. Or talk to your health insurance plan sponsor.

4. Consult with your doctor to make sure you are using the most cost-effective medicine for your condition. When possible, use a generic or preferred brand if a generic is not available. Other ways to lower costs are discussed under the topic "Are there ways to lower my drug costs?"

5. Pay your copay or coinsurance, as applicable.

6. If you take a long-term medication, your plan may require you to use home delivery or a pharmacy that fills 90-day prescriptions. Have your provider write a prescription for up to a 90-day supply with three refills, when appropriate. Please refer to the topic "How do I use home delivery for my maintenance medications?" for additional information.

What if I have questions about my prescription drug coverage?

If you have questions about your prescription drug coverage, please call the Rx Information number on your member ID card.

You may also log in to My Health Plan at MedMutual.com/Rx and click on the Sign on to Express Scripts button. From the Express Scripts website, select Prescriptions and then Price a Medication. From here you can search for a medication name to view cost, any applicable coverage rules, and identify preferred alternatives. For an overview of our prescription drug benefits, select Benefits and then Benefits Overview.

Are there ways to lower my drug costs?

Your copay may vary if you use an in-network retail pharmacy or home delivery pharmacy. There may also be a level of copay or coinsurance specific to generic, preferred brand, non-preferred brand and/or specialty prescription drugs.

Always discuss using generics first with your healthcare provider. Generic drugs approved by the Food and Drug Administration (FDA) are just as safe and strong as the corresponding brand name drugs. Depending on your plan, you will typically have a lower cost share for generic drugs as well as preferred brand drugs when compared to non-preferred brand drugs.

If you are an existing member, you can check medication coverage and pricing information for home delivery and retail pharmacies by logging in to My Health Plan at MedMutual.com/Rx. Click the Sign on to Express Scripts button, then click Price a Medication under the Prescriptions tab. Then you will see the following information:

- Formulary drugs (your plan's preferred generic and brand-name drugs)
- Cost-saving opportunities personalized to your prescriptions and your prescription drug plan
- Alternatives ranked by best value
- Brand-to-generic and/or retail-to-home delivery cost-saving options
- Determine generic availability

You can also contact Express Scripts by calling the Rx Information number on your member ID card.

How do I use home delivery for my maintenance medications?

Depending on your plan, you may be required to use home delivery for your maintenance medications (those you take for three months or more). Check your Certificate or Benefit Book for details. Even if you are not required to do so, you may save money on your maintenance medications if you use home delivery. Please refer to the topic "Are there ways to lower my drug costs?" to find out how to look up pricing information for retail and home delivery. **Note:** If you are a member of a CLE-Care plan, you must fill mail-order medications through the MetroHealth Mail Order Pharmacy. Visit MetroHealth.org/Pharmacy for more information and to download a form.

You may be able to enroll in Express Script's Extended Payment Program with no additional fees. This allows you to split your cost into three equal monthly payments while still obtaining the full amount of your prescription (limitations may apply). To learn more about the Extended Payment Program, call the Rx Information number on your ID card.

To get started using home delivery, ask your healthcare provider to write a prescription for up to the maximum days' supply allowed by your plan, usually a 90-day supply, plus refills for up to one year. Your healthcare provider can e-prescribe or fax your prescription directly to Express Scripts; or you can mail your prescription with a completed home delivery form and payment to Express Scripts. You can contact the Rx Information number on your ID card if you need help transferring your prescriptions to home delivery. You can also transfer your existing prescription to mail order online through the Express Scripts website. Log in to My Health Plan at MedMutual.com/Rx and click on the Sign on to Express Scripts button. From the Express Scripts website, choose Prescriptions and then Pharmacy Options to select the medication(s) you want to include in home delivery.

When ordering through home delivery, your medication should be delivered in about eight days (10-14 days if it's a new prescription). Please have a sufficient supply of your medicine on hand when you place your order. Once your prescription has been sent by your healthcare provider, call the Rx Information number on your ID card to reach Express Scripts to confirm your prescription was received and to provide additional payment and allergy information. Express Scripts cannot process your prescription without this information. You can check your order status and order additional refills for existing and unexpired prescriptions by visiting the Express Scripts website through My Health Plan, or by calling the Rx Information number on your ID card. For helpful tips to get started with home delivery, watch our video at MedMutual.com/MailOrder or view our brochure at MedMutual.com/PrescriptionHomeDelivery.

Are specialty drugs covered by my plan?

In most cases, specialty drugs will be covered by your plan. For best price and service, your plan may require you to use one of our contracted specialty pharmacies to fill these prescriptions: Accredo Specialty Pharmacy, Gentry Health Services or University Hospitals of Cleveland Specialty Pharmacy.

In addition, when filling specialty medications at Accredo, Gentry or University Hospitals of Cleveland Specialty Pharmacy, only the amount you actually pay out of pocket will accumulate toward your annual deductible and/or maximum out-of-pocket amount. For example, if your medication costs $500 and you use a manufacturer's coupon to pay $450 of the cost, only the $50 you pay out of pocket will be applied toward your annual deductible and/or maximum out of pocket.

Are there any limitations on medications my doctor might order?

Some medications may have quantity limits, require prior approval or have other requirements that must be met before your prescription will be covered. For some formularies, certain medications may be excluded from coverage and are referred to as non-formulary drugs. You can call the Rx Information number on your ID card and ask if your medication is subject to limitations or prior approval requirements.
To determine coverage rules, log in to My Health Plan at MedMutual.com/Rx and click on the Sign on to Express Scripts button. To review your medication's coverage notes, select Prescriptions and then Price a Medication.

A coverage review is a process to consider whether prescriptions that are covered only when medically necessary meet the criteria for coverage. To request a coverage review, ask your healthcare provider to complete an electronic prior authorization request through their electronic health record (EHR) system. For assistance or alternative submission options, have your healthcare provider visit the Express Scripts website at ESRX.com/PA or call Express Scripts at 1-800-417-1764 to arrange a review.

Products that are approved by the U.S. Food and Drug Administration for cosmetic use or weight loss are not covered under most prescription benefit plans.

What if my provider prescribes a medication that is non-formulary?

Talk with your doctor or healthcare provider to see if the formulary includes a medication to treat your condition. In most cases, your provider will find one that meets your needs.

In the rare instance that none of the covered medications is appropriate for you and a non-formulary medication is required, you may request an exception to cover the non-formulary medication by asking for a coverage review. Ask your healthcare provider to complete a prior authorization request through their electronic health record (EHR) system. For assistance or alternative submission options, have your healthcare provider visit the Express Scripts website at ESRX.com/PA or call Express Scripts at 1-800-417-1764 to arrange a review.

If an exception is made based on medical necessity, you will only pay your plan's applicable cost share (e.g., generic, non-preferred brand, specialty) for the non-formulary medication. If your provider does not request a coverage review and you fill a prescription for a non-formulary medication, you will pay the full cost.

How can I file an appeal if my prescription drug is not on the formulary or was denied?

Appeals for the medical necessity of a prescription drug are handled by licensed pharmacists or physicians from Express Scripts. Appeals should be submitted with related medical information to the address below within 180 days of receipt of your denial notice. Appeals related to urgent matters will be decided within 72 hours.

Express Scripts

Attention: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
Phone: 1-800-935-6103
(Monday through Friday, 7 a.m.–6 p.m. Central)
TTY: 1-800-716-3231
Fax: 1-877-852-4070

Appeals related to membership eligibility or excluded prescription drugs should be submitted to the address below or may be submitted electronically through your plan's website or by logging into My Health Plan.

Medical Mutual

Member Appeals
P.O. Box 94580
Cleveland, OH 44101-4580
Fax: 1-216-687-7990 or 1-866-691-8260

You will receive notice of appeal decisions in writing. If the original decision is not overturned, our notice will describe any additional appeal rights you have.

How do I file a claim for an out-of-network pharmacy?

If you are unable to use an in-network pharmacy or your pharmacy is unable to electronically file your claim with Express Scripts, you may submit a claim within 12 months of purchasing your medication. Please refer to your Certificate or Benefit Book to make sure your plan covers non-network pharmacies.

To submit a claim electronically, log in to My Health Plan at MedMutual.com/Rx and click on the Sign on to Express Scripts button. From the Express Scripts website, select Forms under the Benefits tab. Next, click on the Start a Claim button to request reimbursement. You may also request a claim form by calling Customer Care at the number on your member ID card.

For additional questions, email Customer Care. To email us, log in to MedMutual.com/Member and go to Contact Us.

Common Medical Terminology

Allowed Amount: The highest amount we will cover (pay) for a service.

Coinsurance: A certain percent you must pay each benefit period after you have paid your deductible. This payment is for covered services only. You may still have to pay a copay.

Copayment (Copay): The amount you pay to a health provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

Covered Charges: Charges for covered services your health plan paid. There may be a limit on covered charges if you receive services from providers outside your plan's network of providers.

Deductible: The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time).

HMO (Health Maintenance Organization): Offers healthcare services only with specific HMO providers. Under an HMO plan, you might have to choose a primary care doctor. This doctor will be your main healthcare provider. The doctor will refer you to other HMO specialists when needed. Services from providers outside the HMO plan are not covered except for emergencies.

Medical Necessity (medically necessary): Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:

- Accepted as standard practice (it can't be experimental or investigational)
- Not just for your convenience or the convenience of a provider
- The appropriate type of service in the most appropriate type of facility that can be given to you

PPO (Preferred Provider Organization): A type of insurance plan that offers coverage for the services of healthcare providers who are part of the plan's network, as well as some coverage for providers who are not part of the plan's network.

Preventive Services vs. Medical Services: Preventive services are those you get before you have any related condition or problem. They are important to maintain your health. Medical services are related to diagnosing, monitoring and treating health conditions.

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Notice of Availability of Language Assistance and Auxiliary Aids and Services

MEDICAL MUTUAL®

English

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-382-5729 (TTY: 711) or speak to your provider.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-382-5729 (TTY: 711) o hable con su proveedor.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-382-5729 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Italian

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' 1-800-382-5729 (TTY: 711) o parla con il tuo fornitore.

Russian

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-382-5729 (TTY: 1-711) или обратитесь к своему поставщику услуг.

French

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-382-5729 (TTY: 711) ou parlez à votre fournisseur.

Chinese

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-982-3117（文本电话：711）或咨询您的服务提供商。

Vietnamese

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-382-5729 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

Arabic

العربيةتنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-382-5729 (TTY: 711)

Korean

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-382-5729 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Cushite/Oromo

HUBACHIISA: Yoo Afaan Oromoo dubbattu ta'e, tajaajiloonni gargaarsa afaanii bilisaa isiniif ni argamu. Deeggarsi dabalataa fi tajaajilootni mijaa'oo ta'an odeeffannoo bifa dhaqqabamaa ta'een kennuuf gargaaranis kaffaltii malee ni argamu. Gara 1-800-382-5729 (TTY: 711) tti bilbilaa ykn dhiyeessaa keessan haasofsiisaa.

Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-382-5729 (TTY: 711) o makipag-usap sa iyong provider.

Romanian

ATENȚIE: Dacă vorbiți Română, aveți la dispoziție servicii de asistență lingvistică gratuite. De asemenea, sunt disponibile gratuit materiale și servicii auxiliare adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-382-5729 (TTY: 711) sau contactați-vă furnizorul.

Japanese

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-382-5729（TTY:711）までお電話ください。または、ご利用の事業者にご相談ください。

Order Number: Z8188-MCA R9.24
Dept of Ins. Filing Number: Z8188-MCA R9.24

Dutch

LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-800-382-5729 (TTY: 711) of spreek met je provider.

Pennsylvania Dutch

WICHDICH: Wann du Deitsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 1-800-382-5729 (TTY: 711) uff odder schwetz mit dei Provider.

Ukrainian

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-382-5729 (TTY: 711) або зверніться до свого постачальника.

Navajo

SHOOH: Diné bee y1ni[ti'gogo, saad bee an1'awo' bee 1ka'an7da'awo'7t'11 jiik'eh n1 h0l=. Bee ahi[hane'go bee nida'anish7 t'11 1kodaat'4h7g77 d00 bee 1ka'an7da'wo'7 1ko bee baa hane'7 bee hadadilyaa bich'8' ahoot'i'7g77 47 t'11 jiik'eh h0l=. Kohj8' 1-800-382-5729 (TTY: 711) hod7ilnih doodago nika'an1lwo'7 bich'8' hanidziih.

Notice of Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Medical Mutual of Ohio complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Medical Mutual of Ohio does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Medical Mutual of Ohio:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator at CivilRightsCoordinator@MedMutual.com.

If you believe that Medical Mutual of Ohio has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

100 American Road
Cleveland, OH 44144

Call: 1-800-382-5729 (TTY: 711)
Email: CivilRightsCoordinator@MedMutual.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator (who is also our Section 1557 Coordinator) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

- Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html
- This notice is available at Medical Mutual's website: www.MedMutual.com

Questions about your benefits or other inquiries about your health insurance should be directed to Medical Mutual's Customer Care Department at 1-800-382-5729.

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