MEDICAL MUTUAL®

How do I get the most from my healthcare benefits?

Member FAQ Guide

KEEP THIS DOCUMENT FOR YOUR RECORDS

What you should know about your health benefits

Health Benefit Focused Questions

Some commonly misunderstood insurance terms

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 healthcare 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 that your health plan pays for. 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).

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

Our products are underwritten by Medical Mutual of Ohio or Medical Health Insurance Company of Ohio.

Welcome to the family!

At Medical Mutual,® we have a long-standing commitment to help our members get the care they need by providing them with access to high-quality healthcare, a large network of doctors and hospitals, and a wide range of health programs.

As part of this commitment, we want to make sure our members understand and get the most out of the benefits we offer. To help you learn more about our services, we are providing this Member FAQ Guide as an easy-to-use, quick-reference tool.

If you are a current member and have more questions, please visit our website, Member.MedMutual.com, and log into our secure member website, My Health Plan. Or call our dedicated Customer Care Center at the number on your identification card. For information about your specific benefits, please refer to your Certificate or Benefit Book.

If you are not a current member, additional resources and information are available on our website, or talk to your employer or broker about the benefits available to you.

We look forward to serving your healthcare needs.

Sincerely,

Rick Chiricosta
Chairman, President and Chief Executive Officer
Medical Mutual

What charges am I responsible for when I receive services?

Amy — College Student

A:

Depending on your health plan, you may be responsible for:

- A copayment at each visit
- An annual individual deductible and/or an annual 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

To find out how much you might need to pay, contact your healthcare provider for information about your diagnosis and expected procedures, then call our Customer Care Center for more information about covered services.

How do I know if a certain procedure, surgery or service is covered by my health plan?

To check your covered benefits, review the Schedule of Benefits section in your Certificate or Benefit Book. Your Certificate or Benefit Book may also be available when you log into your plan's website or My Health Plan. Call our Customer Care Center 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 routine preventive care. Some plans include prescription drug coverage.

"Medically necessary" (or "medical necessity") is defined as a service, supply and/or prescription drug needed to diagnose or treat a condition that we decide is:

- Good medical practice and not experimental or investigational
- Not primarily for your convenience or the convenience of a provider
- The most appropriate supply or level of service that can be safely 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.

Coverage exclusions typically include 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 for a full list of coverage exclusions.

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

We perform an extensive evaluation of the new use of medical technologies, medications, behavioral health procedures and devices to ensure they are medically appropriate for our members. After multiple experts conduct this evaluation, a decision is made whether to include the new service in the coverage provided to 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. This list can be found on My Health Plan by clicking on Prior Approval under the Benefits & Coverage tab.

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

To find a list of network providers:

- Log into My Health Plan and select Find a Provider
- Call our Customer Care Center at the number on your ID card to request a printed directory
- Download our mobile app, available through iTunes or Google Play

What happens if I don't go to healthcare providers in my health plan?

Most plans require you to choose network doctors and hospitals for services to be covered at the highest benefit level.

If you go outside the network, you will be responsible for paying a non-network deductible and coinsurance (the percentage of the provider's bill you must pay after you meet your deductible) and/or excess charges above the allowed amount we would normally pay for covered services. You would also pay for charges for non-covered services and for services we might deny.

If you are a member of an HMO health plan, you do not have out-of-network coverage, other than for emergency services. You will be responsible for paying the charges in full.

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

To find information and qualifications about providers in your health plan's network, call the provider's office or check:

- The My Care Compare tool on My Health Plan
- Your local Academy of Medicine
- The State Medical Board
- The Directory of Medical Specialists, available at most public libraries
- The American Medical Association's Physician Select website: https://apps.ama-assn.org/doctorfinder/

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.

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

Primary care providers can tell you when and where to get specialty, behavioral health and hospital services. Check your Certificate or Benefit Book for mental health disorders and substance abuse benefits. Information about specialists can be found using the My Care Compare tool on My Health Plan.

Do I need prior approval for certain procedures?

Certain services and medications require prior approval for medical necessity before you have the procedure or service—especially if the service is considered experimental or investigational and not eligible for coverage. Prior approval is not a guarantee of payment; payment is subject to your benefits and contract provisions. Visit My Health Plan and click on Prior Approval under the Benefits & Coverage tab to view the services and medications on the Prior Approval List.

How do I get prior approval?

If your provider is in the network, he or she will be responsible for contacting us for prior approval. If your provider is not in the network, you will need to get our prior approval before treatment.

If you are scheduled for a hospital stay, once you have been admitted to the hospital, our nurses will work with your provider to gather information about your condition. Utilization management makes sure your treatment is within the standard of care.

Our utilization management staff can answer your questions about processes, issues or requirements, such as inpatient admissions, denials and appeals (including behavioral health services and issues), Monday through Friday, excluding holidays, from 8:15 a.m. to 4:15 p.m. (EST).

To speak with a Utilization Management or Behavioral Health nurse, please call one of the numbers listed in the chart below:

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

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

Through our Case Management program, our Registered Nurse Case Managers 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.

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

To speak with a Registered Nurse Case Manager Monday through Friday, excluding holidays, select the appropriate phone number from the Care Management chart on page 4. Please call between 7:45 a.m. and 4 p.m. (EST).

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

If you get sick or are in an accident while away from home, call the number on your ID card that is specific to locating a network doctor or hospital, or use our Find a Provider tool on My Health Plan or our mobile app. If you need to be admitted to a hospital, call the prior approval number on your ID card before your stay. If your condition is a medical emergency, go to the nearest emergency room or, if necessary, call 911.

How can I set up an advance directive (e.g., Living Will, Power of Attorney, Do Not Resusitate)?

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, contact the National Hospice and Palliative Care Organization (NHPCO) by phone at (800) 658-8898, or online at nhpco.org.

To find a palliative or hospice care provider in the Medical Mutual network, log into My Health Plan at Member.MedMutual.com. Click Find a Provider then search by Provider Type "Physician" or "Facility," depending on the care you want. If searching by Physician, choose Hospice And Palliative Medicine as your Specialty. If searching by Facility, choose Hospice Center as your Facility Type. You may also locate a palliative or hospice care program through the Find a Provider link on nhpco.org.

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

For your personal benefit information,
visit My Health Plan at:

Member.MedMutual.com

Everything You Need, Everywhere You Are

All your health plan information is located in one secure, online site—My Health Plan on MedMutual.com.

With My Health Plan you can:

- View, print or download up to 24 months of claims
- Locate network providers
- View your plan benefits
- Access interactive tools and health and wellness programs and information

Enjoy the benefits of going paperless:

- Receive alerts as claims are processed
- Protect yourself against identity theft and mail fraud
- Reduce clutter in your home and help the environment

Download the Medical Mutual mobile app to view, fax or email your ID card; find a doctor, hospital or urgent care facility based on your current location; and view your claims, deductible and out-of-pocket spending information.

How does Medical Mutual improve the quality of healthcare?

Greg — Bank Branch Manager

A: We promote and improve the quality of healthcare for members through our Quality Improvement Program, which monitors and evaluates the quality and safety of healthcare our members receive. The program also communicates important clinical information to our members.

To make sure you get the right medical care, we have a team of clinicians who work together to review certain tests, treatments or hospital stays in a process called Utilization Management. We send an appropriate care statement to all employees, management staff and contracted providers who deal with Utilization Management activities.

To view the Quality Improvement Program description, visit MedMutual.com/QualityImprovement.

Decisions are based only on the appropriate use of care and services for the member and their 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 the underutilization of care or service.

How do I submit a claim?

Most network providers will submit a claim for you. If you go to a doctor, hospital or provider that is not in our network, ask them to submit a claim for you on a standardized claim form. If the provider will not submit the claim for you, contact our Customer Care Center or log into My Health Plan for a claim form. Complete the claim form and attach an itemized bill that includes the diagnosis, procedure, date of service, charge and provider's or facility's name and address. Submit the completed form to our office within the timeframe stated in your Certificate or Benefit Book.

If you go to a hospital or provider outside the country, get a copy of all your medical records and an itemized bill. If needed, have your records and bills translated to English. Submit your claim forms, bills, medical records and proof of payment to the address listed on your ID card. Please remember that benefit coverage and limitations still apply. Refer to your Certificate or Benefit Book for details.

Where do I find a claim form?

You can find claim forms by logging into My Health Plan and looking on the Resources & Tools tab or by calling Customer Care.

How can I get care after normal office hours?

When you are ill, injured or feel like you need immediate care, call your primary care provider (PCP) first. Your PCP can assess your symptoms and direct you to the right place to get care. If your PCP's office is closed and you need prompt but not 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.

Symptoms that may require an urgent care or convenience clinic visit include:

- Signs of the flu
- Signs of a sprain
- Signs of a sinus, ear or bladder infection

What is an emergency?

In an emergency, symptoms are severe and serious enough that a person who has no medical training, with an average knowledge of health and medicine, could reasonably expect that the result would be any of the following if immediate medical care is not received:

- 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

Examples of emergencies are shock, chest pain, choking, poisoning, unconsciousness, severe pain, uncontrolled bleeding, hallucinations, delusions and attempted harm to oneself or others.

How do I get emergency care?

During a medical emergency, go to the nearest emergency room or, if necessary, call 911. Contact your provider within 24 hours of the emergency to arrange follow-up care with a network provider if necessary. If you are admitted to a hospital, our Utilization Management department will work with your provider to review your care. You do not need to contact us for prior approval for emergency care.

How can I ask a question or voice a complaint?

If you have a problem or concern, you can:

- Call Customer Care
- Email Customer Care through our website by clicking on Contact Us
- Mail a letter to your benefit administrator or employer or to Medical Mutual, MZ: 22-2S-4807, 2060 East Ninth Street, Cleveland, Ohio 44115

When reviewing your complaint, we will follow the complaint procedure described in your Certificate or Benefit Book.

For additional benefit information, call Customer Care at the number on your card.

Log into My Health Plan to Manage and Improve Your Health

When it comes to your health, find out where you stand. Take our online Health Assessment to learn how healthy you are and identify your risks for certain chronic diseases. Get tips and tools to help manage and improve your health.

Visit Member.MedMutual.com and log into My Health Plan to find the Health Assessment on your homepage. If you do not have access to a computer or the Internet, call Customer Care to get copies of this information.

If you are not a My Health Plan user, register at Member.MedMutual.com. Click on Register Now under Log in to My Health Plan.

Not a member? Try a demo of My Health Plan by clicking Preview My Health Plan.

To track changes in your health status, complete the Health Assessment once a year.

If you have trouble scheduling an appointment with a healthcare professional, you can:

- Complete the Problem Scheduling an Appointment form on My Health Plan in the Resources & Tools section under Forms
- Call Utilization Management (see the Care Management phone numbers chart on page 4)

Can I file a complaint anywhere else?

If applicable to your health plan, you may contact your state's department of insurance. You can find the contact information on your state's website, under state agencies in your phone book or by calling our Customer Care Center. 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 department of insurance after all appeal rights have been exhausted.

Members of self-insured groups (other than a public employee benefit plan) should not file a complaint with the department of insurance. 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 labor union or other self-insured group, you should refer to your Benefit Book for how to file an appeal
- All others may refer to the following appeal procedure

Members may exercise their right to appeal a denial to pay a claim or approve a service or procedure according to the applicable laws of the state where your policy was sold and applicable federal law. There is no charge for filing an appeal.

Your appeal must be filed 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 the fax number and mailing address for 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 in making a decision about your appeal.

Appeals must be filed within 180 days from the date you received your original denial.

An appeal request must come from the patient unless he or she is a minor (in which case a parent or legal guardian of the patient may file the appeal), has appointed an individual as power of attorney representing the patient or has authorized an individual to act as his or her representative.

To appeal a denial for services you need immediately, call Utilization Management or Behavioral Health (see the Care Management phone numbers chart on page 4). Urgent care appeals will be decided within 72 hours, as will appeals for care you need while you are in the hospital. Our decision about all non-urgent appeals will be made within 30 days from the date we receive your appeal request (or sooner according to the laws of your state). You will receive notice of our appeal 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 review my case if it is denied?

Yes. If we deny a claim, do not approve a service or procedure, or reduce or terminate coverage for a healthcare service because it is not covered under the terms of your policy or Certificate, and the department of insurance has jurisdiction over your plan, you may have the option to submit an inquiry to the department of insurance in the state where your policy was sold.

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 the department of insurance in your state. The department of insurance may review the terms of your policy or Certificate and determine whether the healthcare service is a covered service. If a medical issue must be resolved before a determination of coverage is made, you will be notified so the medical issue may be properly reviewed.

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 us unless you are eligible to exercise your 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 law and regulations. You will be told in writing of the IRO's decision.

What are my rights as an ERISA plan member?

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 you decide to proceed with a voluntary appeal, you do not need to exhaust this option prior to pursuing a claim in court.

What are my rights as a member of a public entity (schools and government)?

Public entities are 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.

What are my rights and responsibilities as a member?

Brandy—Wellness Center Personal Trainer

A: 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 the member rights and responsibilities, please call our Customer Care Center at the number on your ID card. This document is also available on our website, MedMutual.com/MemberRights.

Member Rights

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.

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 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.

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 claim.
- 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.

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.

Member Rights (continued)

Participation in Treatment Decisions and in Your Health Plan

- 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 this 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.

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.

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.

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 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 protected health information.
- 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 healthcare 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 translation or speech assistance?

Vitali—Automobile Technician

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

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, if other than English, upon your request. To ask for language assistance, please call Customer Care and inform 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.

Para la ayuda de interpretación de lenguaje por favor póngase en (contacto) con el Servicio de Cliente al número localizado en su tarjeta de identificación.

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

We have strict policies and procedures to protect your personal information, including data on your health information that is stored on our computer systems and in our files. You can view our Privacy Notice on our website for more information on the collection, use and disclosure of members' protected health information (PHI), and how to access, amend or to request a restriction to the use or disclosure of your PHI by us.

How do I exercise my privacy rights?

Visit our website to find information about privacy rights. Look for the HIPAA link in the footer of our website, or call Customer Care.

What should I do if I believe my rights have been violated?

If you feel your rights have been violated, call Customer Care or complete the form located on the HIPAA section of MedMutual.com.

How do I change my personal information?

You can change your personal information (e.g., address, phone number) by logging into My Health Plan at Member.MedMutual.com. Click on My Profile, then Profile Settings to review and make changes. You can also call Customer Care to make any necessary changes to your personal information.

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 need assistance, please call Customer Care.

Prescription Coverage

What procedures should I follow if purchasing prescription drugs?

1. Locate a network pharmacy by logging into My Health Plan and selecting Pharmacy under Find a Provider, or call Customer Care.

2. Present your member ID card to your pharmacist.

3. Pay your copayment or coinsurance, as applicable.

4. If you are unable to use a 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 (refer to your Certificate or Benefit Book to verify your plan covers non-network pharmacies). To get a claim form, call Customer Care, log into your plan's website or log into My Health Plan and select Forms under the Resources & Tools tab.

5. If you take a long-term medication and your plan allows, use mail order. Have your provider write a prescription for up to a 90-day supply with three refills, when appropriate.

6. Choose drugs on the formulary list. The formulary contains a wide selection of brand-name and generic medications that could help lower your costs. To view your formulary, log into My Health Plan and click on Benefits & Coverage then Prescription Drug Benefits. From there, you can be re-directed to the Express Scripts website and select Health & Benefits Information then Learn About Formularies. You may also call Customer Care to request a copy of your formulary guide.

7. Consult with your doctor to make sure you are using the most cost-effective medicine for your condition. When possible, use generics.

Get the Most Out of Your Medical Benefits

Remember these tips to save money and maximize your benefits:

- **Stay in Network**
  For the lowest out-of-pocket cost, see doctors and hospitals in your network. Use our online My Care Compare tool on Member.MedMutual.com to choose one today. Or download our mobile app, available through iTunes or Google Play, and find a provider based on your current location.
- **Know What's Covered**
  Review your benefits online or speak to a Customer Care Specialist to make sure a service is covered.
- **Use a Lower-Cost Facility**
  For minor injuries or illnesses, use an in-network convenience clinic or urgent care facility, or talk to your doctor.
- **Take Care of Yourself**
  Take advantage of preventive services covered at little or no cost to you. Review your benefits online or speak to one of our Customer Care Specialists for a complete list of what's covered by your plan.

What if I have questions about my prescription drug coverage?

If you have questions about your prescription drug coverage, please call our Customer Care Center or Express Scripts Member Services at the numbers on your Medical Mutual ID card.

Are there ways to lower my drug costs?

Your copayment may vary if you use a retail pharmacy or mail-order home delivery. There may also be a level of copayment specific to generic, brand-name formulary or brand-name non-formulary prescription drugs.

Some benefit plans may allow you to use Express Scripts' My Rx Choices program to find cost-saving opportunities for any prescription drugs you might be taking. To access this program if applicable to you, log into My Health Plan and click on Benefits & Coverage, then Prescription Drug Benefits. From there, you can be re-directed to the Express Scripts website, then click on Manage Prescriptions then Save With My Rx Choices and enter the name of your medication. You will see:

- Cost-saving opportunities personalized to your prescriptions and your prescription drug plan
- Alternatives ranked by best value
- Brand-to-generic and/or retail-to-mail cost-saving options
- Over-the-counter alternatives for more than 200 prescription drugs
- Formulary drugs (your plan's preferred generic and brand-name drugs)

My Rx Choices will show you how much you might save with an alternative medication, including generics (if available). Your doctor can review your options and, as appropriate, write a new prescription for you.

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. You can call Customer Care and ask if your medication is subject to limitations or prior approval requirements. You can also determine coverage rules by logging into My Health Plan and clicking on Benefits & Coverage, then Prescription Drug Benefits. From there, you can be re-directed to the Express Scripts website. Review the coverage notes by selecting Manage Prescriptions then Price a Medication. To request a coverage review, have your provider contact Express Scripts at (800) 753-2851. 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.

How can I file an appeal if my prescription drug was denied?

Appeals for the medical necessity of a prescription drug are handled by licensed pharmacists or physicians from Express Scripts. Appeals for medical necessity of a prescription drug, along with related medical information, should be submitted 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: (800) 935-6103
(Monday through Friday, 7 a.m.–6 p.m. Central)
TTY: (800) 716-3231
Fax: (877) 852-4070

Appeals related to prescription drug eligibility or benefit coverage 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: (216) 687-7990 or (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.

If you do not have access to the Internet or prefer to have information explained or provided in a written format, please call our Customer Care Center.

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.

For your personal benefit information,
visit My Health Plan at:
Member.MedMutual.com

Your questions answered

MEDICAL MUTUAL®
2060 East Ninth Street
Cleveland, OH 44115-1355

MedMutual.com

Z7068-COR R7/15