



MEDICAL MUTUAL®

100 American Road
Cleveland, OH 44144-2322

MedMutual.com

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](https://www.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 NCOA 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](https://www.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](https://www.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](https://www.MedMutual.com/Member) 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](https://www.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](https://www.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](https://www.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](https://www.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](https://www.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](https://www.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](https://www.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](https://www.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](https://www.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



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 Sprachassistenzen 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

ة، يبرعلا ةغللا ثدحتت تنك اذا: هي بنتة يبرعلا امك. ةيناجملا ةيوعلل ةدعاسملا تامدخ كل رفوتت سف تامولعمل ريوفوتل ةبسانم تامدخو ةدعاسم لئاسو رفوتت مقرلا يلعل لصتا. أناجم اهليل لوصول انكمي تاقيسي سنن 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。

Dutch

LET OP: als je Nederlands spreekt, zijn er gratis taalhelpdiensten 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

WICHDIH: Wann du Deutsch 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 jiiik'eh n1 h0I=. Bee ahij 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 jiiik'eh h0I=. 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.



 **MEDICAL MUTUAL**[®]
100 American Road
Cleveland, OH 44144-2322
MedMutual.com

Make the Most of Your Membership





Much more

than a health insurance plan

Welcome to Medical Mutual. Our goal is to help you make the best health choices possible while minimizing healthcare costs. We offer a variety of programs, discounts, tools and resources designed to do exactly that.

Many Ways to Save

While Medical Mutual continuously looks for ways to make your health insurance plan more cost effective, there are several things you can do to help reduce your healthcare expenses.

Stay in Network

Save money by using doctors, hospitals, and other healthcare providers and facilities in your plan network. Going outside your plan's network may cost you more, and some services may not be covered at all. Use our Find a Provider tool on My Health Plan, our secure member website, to find providers in your plan's network before receiving any treatment or procedures.

Avoid the ER for Minor Illnesses and Injuries

For injuries or illnesses that are not life threatening, seeing your primary care provider or visiting an urgent care facility or convenience clinic for treatment can be a cost-effective alternative to the emergency room (ER). ER visits can mean long wait times and expensive out-of-pocket costs.

Know What's Covered

Review your plan's Summary of Benefits and Coverage (SBC) before you have a service or procedure to see what's covered. An SBC is a document that summarizes important information about coverage in easy-to-understand language. You can also call our Customer Care specialists at the number on your member ID card for help.

Take Care of Yourself

Preventing a disease is less of a burden than treating a disease. That's why annual checkups with your doctor are so important. Your plan includes preventive benefits that cover well visits, screenings and immunizations. The amount of coverage may vary depending on your particular plan, but out-of-pocket costs will most likely be lower than the cost of treating a condition that has progressed.



MedMutual Total Health™

Programs and Discounts

With Total Health, you receive access to personalized, top-tier clinical resources that help improve your overall well-being and save money by addressing health risks as early as possible.

Managing Chronic Conditions

Programs like digital and telephonic health coaching, advanced remote monitoring, and virtual physical therapy offer customized support to meet your needs and help you achieve your personal health goals. You are eligible to participate at no cost if you have been diagnosed with any of these chronic conditions:

- Asthma
- Heart Failure (HF)
- Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Hypertension
- Musculoskeletal pain
- Pelvic health issues (for individuals with vaginal anatomy, regardless of gender identity)

Call our Population Health Support Specialists at 1-800-590-2583 to learn more or to enroll. Specialists are available Monday through Friday from 8 a.m. to 4 p.m. (confidential voicemail available 24/7).



Maternity Support

If a new baby is on the way, download the MedMutual Maternity app. It features a variety of resources and tools to help families prepare for baby's arrival. Visit [MedMutual.com/MaternityApp](https://www.MedMutual.com/MaternityApp) to learn more.

For pregnancies that are considered high-risk, we offer access to a registered nurse who specializes in high-risk maternity care. Call our Case Management team at 1-800-258-3175 to learn more.

WeightWatchers®

Medical Mutual members save almost 50% off the regular cost of a WeightWatchers membership. For more information, call 1-800-251-2583 or visit [MedMutual.com/WeightWatchers](https://www.MedMutual.com/WeightWatchers).

Pivot (Tobacco Cessation)

Want to quit the tobacco habit? We've partnered with Pivot to help you quit for good. Pivot is a personalized app that offers content tailored to your goals, direct access to a health coach and nicotine replacement therapy at no charge. Visit [Pivot.co/MedMutual](https://www.Pivot.co/MedMutual) to get started. Want to quit the tobacco habit? We've partnered with Pivot to help you quit for good. Pivot is a personalized app that offers content tailored to your goals, direct access to a health coach and nicotine replacement therapy at no charge. Visit [Pivot.co/MedMutual](https://www.Pivot.co/MedMutual) to get started.

24-Hour Nurse Line

If you have a health question, minor injury or medical question, you can get answers 24/7 from a clinical expert. Staffed by fully qualified, registered nurses, our Nurse Line is available at no charge to members. Just call 1-888-912-0636 and have your member ID number ready.

Fitness Discounts

Save money on gym memberships, home exercise equipment, nutrition programs and more. Log in to My Health Plan and click Healthy Living, then Fitness.

Other Discounts

We've partnered with several vendors to offer discounts on a variety of unique health products and services. You can find more details on My Health Plan under the Healthy Living tab.

My Health Plan

Gain More Control of Your Health Benefits

My Health Plan, our secure member website, makes it easy and convenient to manage your plan and your health online. You can even compare your healthcare options so you can make better decisions and minimize costs.

You can check your deductible, review your Explanation of Benefits (EOB) statements, find a doctor, compare costs and access a wealth of valuable information to help keep you healthy. Plus, you will find information on a variety of programs, discounts, money-saving tools and educational resources.

Creating your account is simple. Just visit [MedMutual.com/Member](https://www.MedMutual.com/Member). Click on the Register for an Account button.

The screenshot shows the 'My Health Plan' dashboard for a user named Jane C. Doe. The page includes a navigation menu with options like 'Dashboard', 'Claims & Balances', 'Benefits & Coverage', 'Resources & Tools', 'Healthy Living', and 'My Profile'. The main content area displays the user's deductible and coinsurance status, a claims snapshot table, and a notification to confirm an email address.

Deductible & Coinsurance (In Network)

Viewing: Family | Benefit Period: January 1st through December 31st

Deductible \$4086.00 out of \$5200

Coinsurance \$63.00 out of \$1800

Claims Snapshot (Most Recent)

DATE OF SERVICE	TYPE	CLAIM #
07/12/2020	Medical	0004446784-000
07/12/2020	Medical	0014446784-000
07/12/2020	Medical	0034446784-000
07/12/2020	Medical	0035409979-000
07/01/2020	Medical	0056720719-000

Buttons: View Details, View Your Claims



Get to Know My Health Plan

Claims & Balances

Under this tab, you can view claims, check the balances of your health savings account (HSA), flexible spending account (FSA) or health reimbursement arrangement (HRA) and see detailed information about deductibles and coinsurance. If you have an individual plan, you can also pay your premium.

Benefits & Coverage

Discover the benefits of your health insurance and see what your plan covers by clicking on this tab. View your plan details, including medical benefits, maximums and coinsurance, and print temporary ID cards.

Provider Search and Cost Comparison Tools

Our enhanced Find a Provider tool makes it easy to find in-network providers. Search by specialty, location, condition and more. You can also view quality ratings of network doctors and compare costs so you can make the best decision for your health and wallet.

Go Paperless

Choose to receive your EOB statements, SBC, and other communications from Medical Mutual electronically instead of through the U.S. Mail.



MedMutual Mobile App

Get access to the health plan information you need wherever you are. You can track claims and spending information, use the Find a Provider tool and access your ID card. You can even email or fax your ID card to your provider.

You can find the MedMutual app in the App Store® or Google Play™. Or, scan the QR code to download it now.

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Where to Find Care

Understanding your options can help you save time and money



When it comes to taking care of yourself or your loved ones, you want to get the best care as quickly and affordably as possible. When you are ill, injured or feeling like you need immediate care, always call your primary care physician (PCP) first. If you can't reach your PCP or you don't have time for an office visit, you have options.

Telehealth

A service that allows you to connect with your provider virtually using a smart phone, tablet or computer. Many providers offer scheduled telehealth appointments. You may also have access to an on-demand telehealth service that is available 24/7. Please reference your certificate/benefit guide for more information about telehealth services available to you or call Customer Care at the phone number on your ID card.

Convenience Clinic

A walk-in clinic located in some drug and grocery stores, staffed by a physician's assistant or nurse practitioner. Convenience clinics don't require an appointment and have shorter than average wait times.

Nurse Line

A free call-in service offered by Medical Mutual, providing 24/7 access to registered nurses for answers to your health-related questions. Call 1-888-912-0636.

Urgent Care

A walk-in clinic that saves time and money compared to an emergency room. Many are open evenings and weekends. Urgent care facilities don't require an appointment and have average wait times.

Emergency Room (ER)

A facility located in a hospital, providing 24/7 care in case of emergencies. ER visits for non-emergency symptoms may result in extremely long wait times and significantly higher costs.

When traveling outside the U.S., emergency room visits are covered for the treatment of Emergency Medical Conditions in the location you are visiting. You may be asked to pay for the service up front but you may be reimbursed for covered emergency services by submitting an itemized bill to Medical Mutual.

Symptom Reference Chart



	ER/911	Urgent Care	Convenience Clinic	Primary Care Physician	Telehealth
Allergic reactions*	●	●		●	
Allergies		●	●	●	●
Annual preventive care visit				●	
Anxiety	●			●	
Asthma		●		●	
Back pain (minor)		●	●	●	
Bleeding (heavy)	●				
Broken bone (major)	●				
Broken bone (minor)		●		●	
Bronchitis		●	●	●	●
Change in vision (sudden)	●				
Chest pain	●				
Cold and flu symptoms		●	●	●	●
Cut/burn (major)	●				
Cut/burn (minor)		●		●	●
Depression	●			●	
Ear infection		●	●	●	●
Head injury (severe)	●				
Infection		●		●	
Insect bite		●		●	●
Pink eye		●	●	●	●
Rash		●		●	●
Respiratory infection		●	●	●	●
Shortness of breath	●				
Sinus problems		●	●	●	●
Spinal injury	●				
Sprain or strain		●		●	●
Suicidal thoughts	●			●	
Trouble speaking (sudden)	●				
Urinary tract infection		●	●	●	●
Vaccinations (also flu shots)			●	●	
Wheezing		●		●	
X-ray		●		●	

*Severe allergic reactions, such as tongue/throat swelling, difficulty speaking, swallowing or breathing should be seen in an ER.

Please Note: This is a sample list of services and may not be all-inclusive. This does not take the place of professional medical advice, diagnosis or treatment. Although this information is intended to help make the best decision for care, if you feel that your situation is life-threatening, go to the nearest emergency room.

Upgraded Access to Your Health Benefits

The re-designed MedMutual Mobile App

We've made managing your Medical Mutual health plan simpler and more convenient with our re-designed and re-imagined MedMutual mobile app.

Review your claims and EOBs

You can even see a breakdown of each claim to help you clearly understand your benefits and responsibilities.

View your ID cards

Email or fax your ID card to a provider right from your mobile device.

Keep track of costs

View your deductible, coinsurance, copays, and maximum out-of-pocket costs.

Find care and estimate costs

Locate providers in your network, view their ratings and compare costs for tests and procedures.

Manage your prescriptions

Instantly check, order, and track all your prescriptions with fast home delivery.

Pay your premium

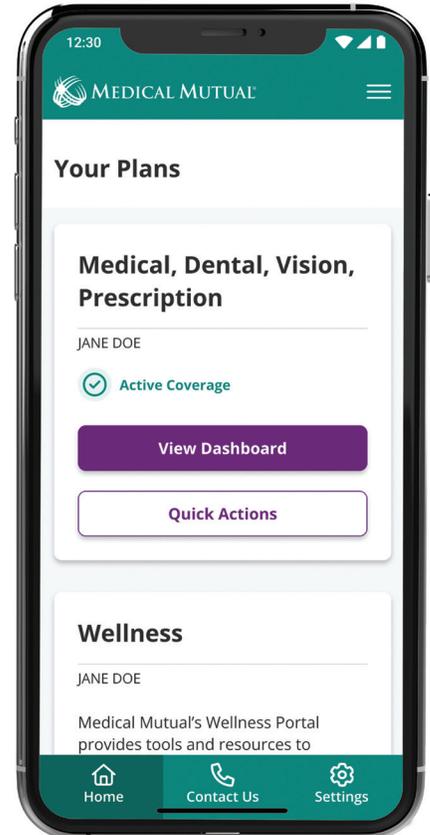
If your monthly premium isn't automatically deducted from your paycheck, experience secure and hassle-free payments through the mobile app.

Engage with your wellness

Our wellness portal includes an array of articles, videos, and online courses to help you maintain or achieve better health.

Download & sign up today!

Search MedMutual in the [Apple App Store](#)® or [Google Play](#)® and easily create an account with our step-by-step instructions.



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My Health Plan

Step by Step Registration Process

My Health Plan makes it easy and convenient to manage your plan and your health online. Please keep in mind that My Health Plan features and functionality are subject to change. If you have questions, please call Customer Care at the number on your ID card.

1. In your internet browser, visit [MedMutual.com/Member](https://www.MedMutual.com/Member).

Click on Register for an Account to get started.

MEDICAL MUTUAL Contact Us: 800.382.5729

My Health Plan

Log In to My Health Plan

Username
Username

Password
Password

[Forgot Username or Password](#)

Log In

Not Registered?

Register now to enjoy 24 hour access to:

- Reference claims and payment information
- View your plan benefits
- Learn more about wellness programs
- Access money-saving tools and tips
- Participate in exclusive members-only offers

Register for an Account

Take A Test Drive

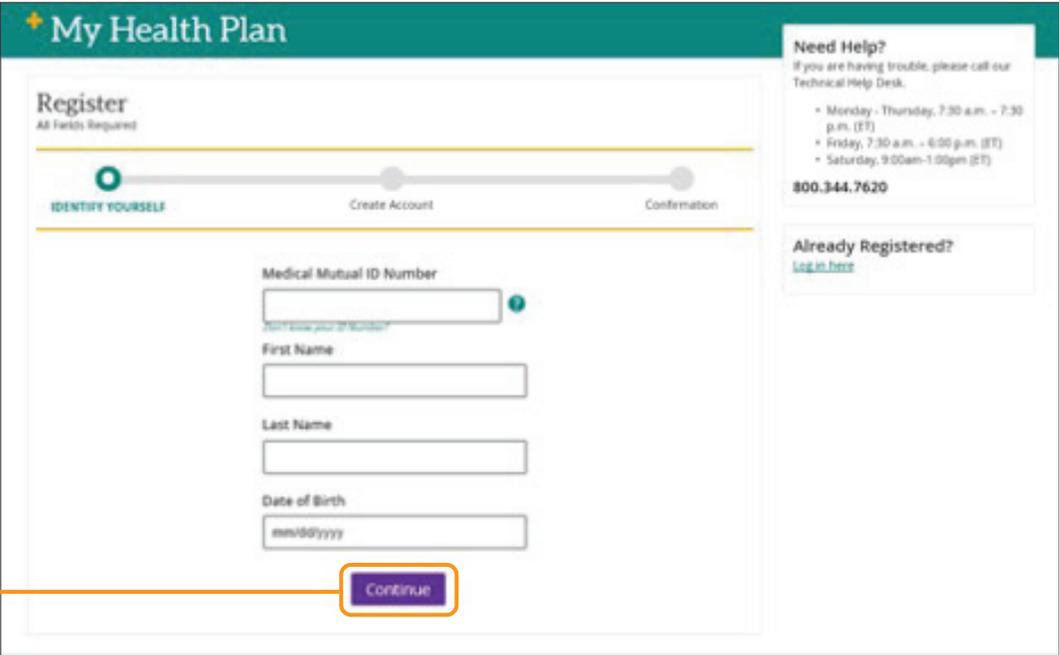
Preview My Health Plan with the Jane Doe account.

Launch Demo Account

2. Enter your ID number, first and last name, and date of birth.

If you do not have your ID number, you can select the “Don’t know your ID Number?” question for additional information about the other accepted forms of identification.

Once you have entered all fields, click Continue.



The screenshot shows the 'My Health Plan' registration page. The main heading is 'Register' with the subtext 'All Fields Required'. A progress bar at the top indicates three steps: 'IDENTIFY YOURSELF' (active), 'Create Account', and 'Confirmation'. The form fields are: 'Medical Mutual ID Number' (with a 'Don't know your ID Number?' link), 'First Name', 'Last Name', and 'Date of Birth' (with a 'mm/dd/yyyy' placeholder). A 'Continue' button is highlighted with an orange box and a mouse cursor. On the right, there is a 'Need Help?' section with contact information for the Technical Help Desk and a 'Already Registered?' section with a 'Log in here' link.

My Health Plan

Register
All Fields Required

IDENTIFY YOURSELF Create Account Confirmation

Medical Mutual ID Number
 [Don't know your ID Number?](#)

First Name

Last Name

Date of Birth

Continue

Need Help?
If you are having trouble, please call our Technical Help Desk.
• Monday - Thursday, 7:30 a.m. - 7:30 p.m. (ET)
• Friday, 7:30 a.m. - 6:00 p.m. (ET)
• Saturday, 9:00am-1:00pm (ET)
800.344.7620

Already Registered?
[Log in here](#)

3. Follow the prompts to create an account. Select the Terms and Conditions checkbox, then click Submit.

MEDICAL MUTUAL® Contact Us: 800.382.5729

+ My Health Plan

Register

All Fields Required

Identify Yourself **CREATE ACCOUNT** Confirmation

Username
Password
Confirm Password
Email
Confirm Email

Go Paperless [Show Terms and Conditions](#)

Agree to Registration Terms and Conditions [Show Terms and Conditions](#)

Submit

Need Help?
If you are having trouble, please call our Technical Help Desk.
• Monday - Thursday, 7:30 a.m. - 7:30 p.m. (ET)
• Friday, 7:30 a.m. - 6:00 p.m. (ET)
• Saturday, 9:00am-1:00pm (ET)
800.344.7620

Already Registered?
[Log in here](#)

4. You should receive an email from Medical Mutual asking to confirm your email address. In the email, click Confirm Email.

MEDICAL MUTUAL® [My Health Plan](#) | [Provider Search](#)

Dear [REDACTED]

An email address was recently added, changed, or confirmed for your account on My Health Plan, Medical Mutual's member website.

Please confirm your email address by clicking the button below:

Confirm Email

If you have questions about this action or need further assistance, call Customer Care at 800-344-7620.

5. Once your email has been confirmed, go back to your browser and click I have confirmed my email.

MEDICAL MUTUAL Contact Us: 800.382.5729

+ My Health Plan

Register

Identify Yourself Create Account CONFIRMATION

Please Confirm Your Email Address Before Logging In
A confirmation email has been sent to the email address provided. Please follow the link in your email to complete the registration process in order to start using My Health Plan.

[I have confirmed my email](#)

Didn't receive the email?
Please check your spam folder or click the resend link below.

[Resend Email](#)

Need Help?
If you are having trouble, please call our Technical Help Desk.

- Monday - Thursday, 7:30 a.m. - 7:30 p.m. (ET)
- Friday, 7:30 a.m. - 6:00 p.m. (ET)
- Saturday, 9:00am-1:00pm (ET)

800.344.7620

Already Registered?
[Log in here](#)

6. Enter the password you just created for your account. Your username will pre-populate.

MEDICAL MUTUAL Contact Us: 800.382.5729

+ My Health Plan

Log In to My Health Plan

Username

Password

[Forgot Username or Password](#)

[Log In](#)

Not Registered?
Register now to enjoy 24 hour access to:

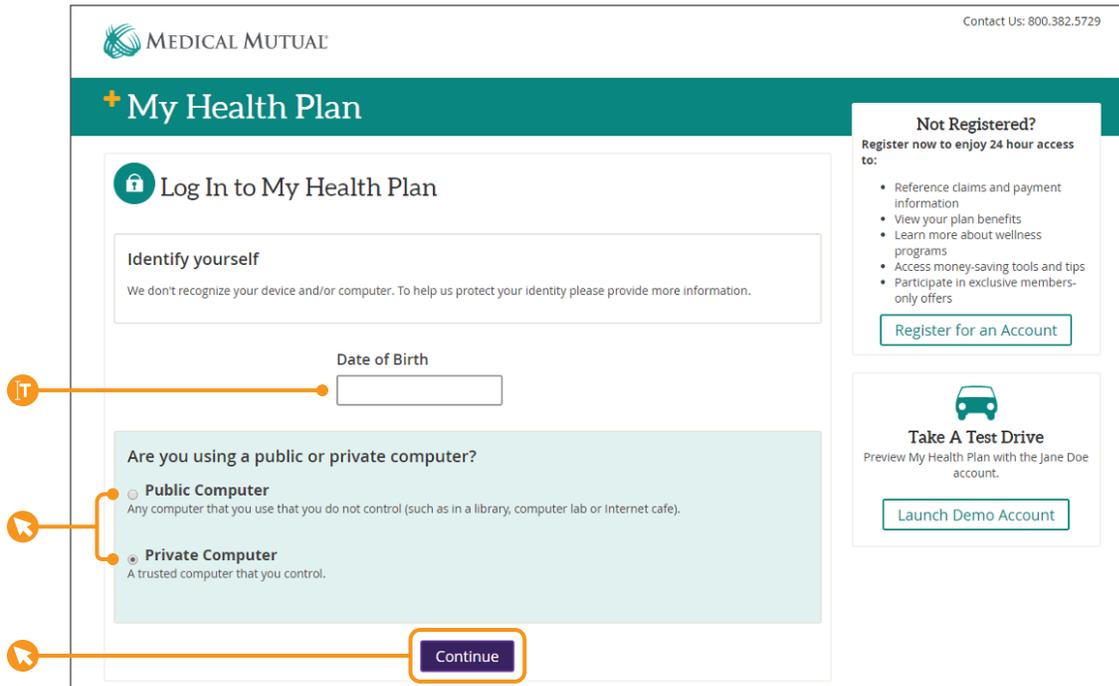
- Reference claims and payment information
- View your plan benefits
- Learn more about wellness programs
- Access money-saving tools and tips
- Participate in exclusive members-only offers

[Register for an Account](#)

Take A Test Drive
Preview My Health Plan with the Jane Doe account.

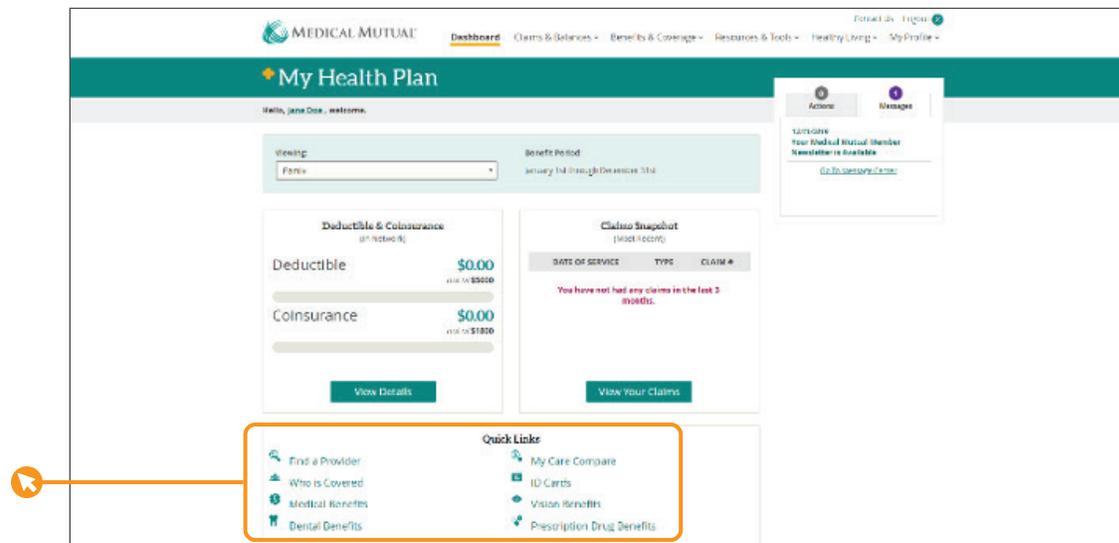
[Launch Demo Account](#)

7. Enter your date of birth, then select the type of computer you are using. Click Continue to log in to the portal.



Next, explore some of the key features of My Health Plan.

View a snapshot of your claims and cost sharing balances on the Dashboard. Use the Quick Links at the bottom of the Dashboard to access our most popular features.



Telehealth Services

Connect Anywhere with a Healthcare Provider

Telehealth appointments allow you to connect with a healthcare provider and obtain needed care through live video chats using a computer or mobile device.

Telehealth Services Available to You

To see what services are available and covered under your plan, check your benefits in My Health Plan or call Customer Care using the number on your ID card.

MinuteClinic Virtual Care

MinuteClinic® offers virtual healthcare visits for adults and children 18 months and older. You can get convenient care within minutes, 24 hours a day, seven days a week, including holidays. MinuteClinic Virtual Care offers care for the following conditions and more:

- Minor illnesses, like colds, the flu, seasonal allergies and sinus infections
- Minor injuries, like bug bites, sprains and strains
- Skin conditions, like eczema and rashes
- Women's services, like urinary tract infections (UTIs) and birth control consultations
- Medication refills

Go to MinuteClinic.com/VirtualCare to learn more and get started.

SonderMind®

SonderMind offers fast and convenient access to high-quality mental healthcare. With their easy-to-use portal, you can schedule either virtual or in-person sessions, message your therapist, submit payments and view your progress over time. Therapy is available for individuals, couples and families of all ages, with over 40 specialties and 60 treatment approaches to meet your unique needs.

Go to Sondermind.com to learn more and get started.

You can also easily access these services through your My Health Plan account at MedMutual.com/member.

Frequently Asked Questions on Telehealth

Are telehealth visits covered under my plan?

As with any health benefit, how telehealth visits are covered depends on the Medical Mutual plan in which you are enrolled. You can use telehealth on-demand for acute conditions such as a sore throat or sinus infection. You can also schedule a telehealth visit to help manage chronic health conditions such as diabetes or high blood pressure. Generally speaking, scheduled telehealth visits are covered the same as standard office visits. Behavioral health visits are not covered in on-demand settings.

Note: To see what is covered under your plan, log into My Health Plan and check your benefits under Benefits & Coverage, or call Customer Care using the number on your ID card.

Do I need to make an appointment for a telehealth visit?

You can make an appointment for a telehealth visit with a provider just like you would a regular office visit. If you need to speak to a healthcare provider right away, you can use an on-demand telehealth service like MinuteClinic Virtual Care,[™] which is covered by your plan. An on-demand telehealth visit is similar to walking into an urgent care center. You do not need to schedule an appointment.

What is the cost for a telehealth visit?

If you have any questions related to your benefits and estimated costs, please contact Medical Mutual Customer Care at the number on your ID card or visit your My Health Plan account.

Do I need any special equipment to participate in a telehealth visit?

Telehealth visits can be done through a smartphone, tablet or computer. Most devices have cameras built in, or you can use a standalone webcam. The healthcare provider you are seeing will let you know what you'll need to connect for your telehealth visit.

How should I prepare for a telehealth visit?

Check your internet connection and test your camera before logging in for your telehealth visit. Here are a few additional tips:

- Try to find a quiet space where you can have a private conversation with the provider.
- Be prepared to explain your symptoms and any health concerns.
- Make a list of medications or supplements you're taking and ask for refills, if needed.
- Note any allergies and discuss them with the provider.

The MedMutual Maternity App

Resources to help you prepare for baby's arrival

If a new baby is on the way, the MedMutual Maternity app can help you manage your health journey with articles, tips and to-do lists that will keep you on track. Plus, easily connect with Medical Mutual resources with just one click.

MedMutual Maternity App Features and Benefits

The app can provide you with:

- Week-by-week updates during your pregnancy
- Daily tips and affirmations
- A tool to look up symptoms and issues
- Screening for high-risk pregnancy and support from our clinical team
- Due date calculator
- Weight gain calculator
- Baby Boost relaxation tool
- Feeding and diaper tracker
- Developmental milestones from birth to age 2
- Health profiles for the whole family
- Articles about health and wellness

You can find the app by searching MedMutual Maternity in the Apple App Store® and Google Play.® Once you have downloaded the app to your device, it's simple to create an account by entering your Medical Mutual member ID number and your date of birth.



MedMutual
Maternity

Download the App.



Pregnancy Check-in Surveys

Upon enrollment, we encourage you to take a short survey so we can see if you are getting all the support you need. You will also have the opportunity to check in with us throughout your pregnancy by taking an additional survey as often as you like.

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My Health Plan

Access your Medical Mutual healthcare plan online 24/7



A secure website specifically for Medical Mutual members, My Health Plan makes it easy and convenient to manage your plan and your health online.



Manage Your Plan

- Search for in-network providers, hospitals and facilities to maximize your benefits
- Order a new member ID card or access a temporary ID card if you don't have yours with you
- View your plan documents to see what is covered



Manage Your Costs

- Check the status of your deductible and coinsurance
- View your Explanation of Benefits (EOB) statements
- Access your health savings account (HSA), flexible spending account (FSA) or health reimbursement arrangement (HRA) if applicable to your plan



Manage Your Health

- Learn about preventive care and mental health resources available to you
- Access our wellness portal for recipes, interactive fitness challenges, online courses and videos.
- Get support you need to help manage a chronic condition

To access My Health Plan or register for your account, visit [MedMutual.com/Member](https://www.MedMutual.com/Member)

Prescription Drug Coverage

How to manage your benefits

Medical Mutual partners with Express Scripts to help you manage your prescription drug benefits. To access the Express Scripts website, log in to My Health Plan at [MedMutual.com/Member](https://www.MedMutual.com/Member) and click “Prescription Drug Benefits” under the Benefits and Coverage tab.

The Express Scripts site shows medications prescribed to you and your dependents and offers options for filling and refilling them. You can also compare costs and see the status of any medications that require a prior authorization from your doctor.

Price a Medication

Under the Prescriptions dropdown menu, select Price a Medication to see how much a prescribed drug will cost. Just enter the name of the drug, select whom the drug is for, enter your ZIP Code and click on the Get Prices button. You'll see a list of the drug's cost at local pharmacies and the cost if you order directly from Express Scripts. You can also see generic or preferred drug options.

Prior Authorizations

Some medications may require a prior authorization, or approval, from your doctor before they are filled. This ensures the drug is both appropriate for your condition and cost effective for you. To see if your medication requires prior authorization, click the Price a Medication tab or call the Rx Information number on your Medical Mutual member ID card. Prior authorization follows the four-step process below. To check the status of a medication, select Prior Authorizations from the Prescriptions dropdown.

Step 1 - Inquiry Received: The prior authorization case request for your medication has been received and is currently being processed.

Step 2 - Outreach to Prescriber: There are additional questions regarding this prior authorization and your prescriber has been contacted to discuss further.

Step 3 - In Review: Everything needed to make the best decision for your condition and your benefit plan has been collected. Review is pending for a final decision (This typically takes 24-48 hours.)

Step 4 - Approved, Denied, Withdrawn or Other: Determination on the outcome of your prior authorization request is reached.

Prescription Home Delivery

If you take long-term medications, such as those used to treat high blood pressure, high cholesterol or diabetes, you could save time and money by having them delivered conveniently to your home through home delivery from Express Scripts. To learn more about home delivery and see how to get started, view our brochure at www.MedMutual.com/PrescriptionHomeDelivery. You can also watch our video on home delivery here: www.MedMutual.com/MailOrder.

Questions?

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



Introducing SmartShopper®

As a member of Medical Mutual, you now have SmartShopper as part of your benefits plan. It's an easy-to-use tool that helps you save money on over 70 medical procedures – and earn cash rewards!

Earn a cash reward up to \$750 with SmartShopper

Prices for the same procedure can vary greatly by location. With SmartShopper, it's quick and easy to compare high-quality, in-network locations before you go. And by choosing a cost-effective one, you earn a cash reward!

It's Simple To Use



Compare locations at [MedMutual.com/SmartShopper](https://www.medmutual.com/SmartShopper) or call the Care Concierge Team at **877-292-1541**.



Go to a reward-eligible location for your procedure.



Earn a cash reward up to **\$750!**



The Care Concierge Team is here to support you. Not only can they help you compare costs, but they can even take care of prior authorizations and scheduling your procedure for you. Call today!

Go green by going paperless! Scan the QR code or contact us to register your email today.

The Care Concierge Team is available Monday through Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 6 p.m. ET.*



*Summer hours: The Care Concierge Team closes at 3 p.m. ET on Fridays from Memorial Day to Labor Day.

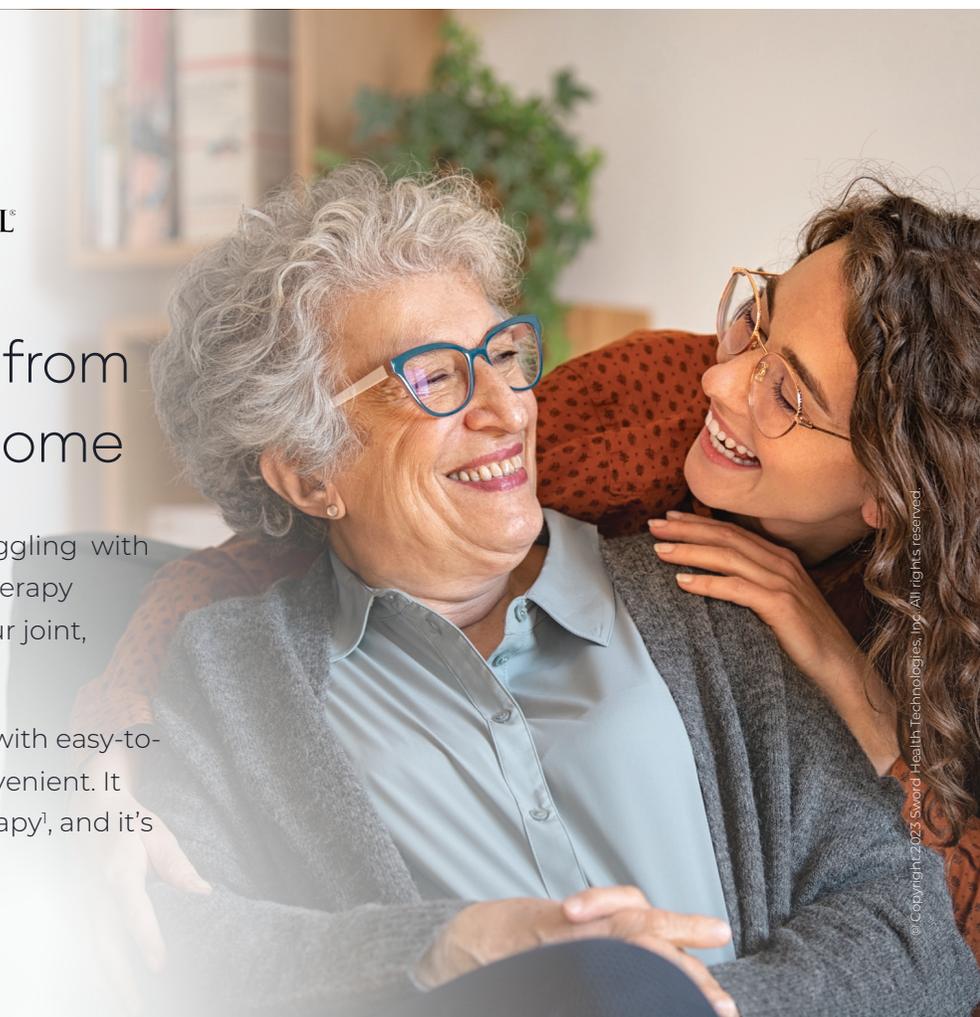
The SmartShopper program is offered by MDX Medical, LLC, a Zelis company. Reward-eligible options and reward amounts are subject to change. Rewards are available for select procedures only. Rewards may be a taxable form of income. MDX Medical, LLC, a Zelis company, does not provide tax advice. Rewards may be delivered by check or an alternative form of payment. Members with primary coverage under Medicaid or Medicare are not eligible to receive incentive rewards under the SmartShopper program.

The SmartShopper program shall not modify the covered person's underlying benefits plan. Any covered service must comply with all plan terms to be eligible for coverage under the plan.

Relieve aches + pain from the comfort of your home

Tired of chronic pain or loss of mobility? Struggling with discomfort? Meet Sword, a digital physical therapy program designed to help you overcome your joint, back or muscle pain—all from home.

Combining licensed physical therapists (PT) with easy-to-use technology, Sword is more than just convenient. It can be as effective as in-person physical therapy¹, and it's available to you at no additional cost.



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Here's how it works



Pick Your PT

Thanks to your dedicated PT, your Sword program is entirely customized to you, your goals and your abilities.



Get Your Sword Kit

Your kit comes with your own tablet, and will provide you and your PT with real-time feedback.



Stay Connected

Chat 1:1 with your PT anytime. They'll check in, monitor your progress, and adjust your program as needed.



Feel the Relief

Complete your exercise sessions whenever is most convenient for you. Then feel pain relief for yourself.

Pain doesn't wait. Why should you?
Enroll today to get started!

join.swordhealth.com/medmutual/register



Available to you and eligible family members 13+ at no additional cost as part of Medical Mutual's Chronic Condition Management Program.

¹ Correia, F. D., Nogueira, A., Magalhães, I., et al. (2018). Home-based rehabilitation with a novel digital biofeedback system versus conventional in-person rehabilitation after total knee replacement: A feasibility study. *Scientific Reports*, 8(1). <https://doi.org/10.1038/s41598-018-29668-0>

Medical Mutual 24/7 Nurse Line

Immediate consultation with a nurse is just a phone call away

Speak with a trained nurse to help you determine the care you need

Your coverage with Medical Mutual provides 24/7 access to highly trained and experienced nurses to help:

- Advise you personally, no matter the size of the concern
- Provide easy-to-understand explanations about medical tests and results
- Talk you through self-care for treating minor medical conditions at home
- Help determine if you need to visit your doctor, an urgent care clinic or the emergency room
- Assess symptoms using nationally accredited guidelines
- Stay on the line until you feel you understand next steps



Highly trained and experienced nurses take your call

Call toll-free to speak with a medically trained, compassionate nurse anytime, day or night, whenever you have a health concern. They will help you understand your situation and determine next steps. You will always speak with a live nurse first without being triaged or put on hold.

Health counseling, education and help with symptom identification

A nurse will evaluate your symptoms, provide an assessment and help you take the most appropriate action. Medical Mutual's Nurse Line staff will help you make the most informed decisions about how to handle a variety of health and wellness concerns and connect you with the appropriate resources. If it's an emergency, the nurse will tell you what steps to take immediately and will follow up later to see how you're doing.

Nurse Line is a valuable health benefit

Nurse Line is available 24/7 to Medical Mutual members at no additional charge. It's a convenient and easy way to get answers to your health care questions—even when your doctor's office is closed.

“The nurses are very knowledgeable. They take the time to find out exactly what’s wrong, so I can make a better decision.”

24/7 Medical Mutual Nurse Line: 1-888-912-0636

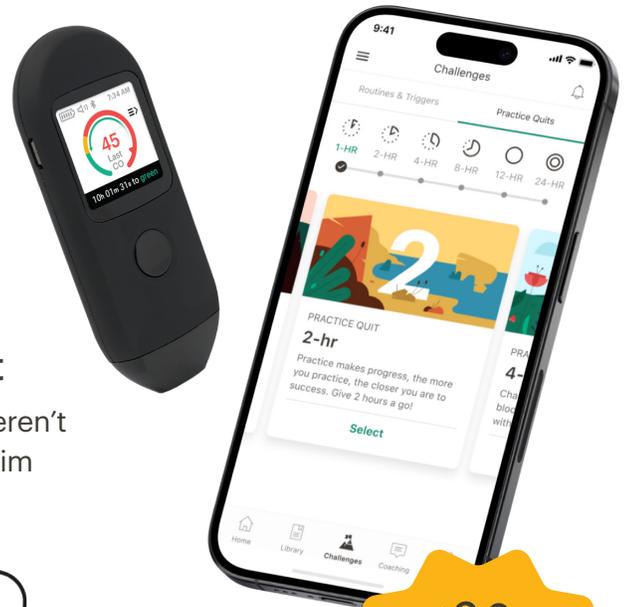


This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. The service is not an insurance program and may be discontinued at any time.

Pivot now, quit smoking when you're ready

There's no pressure to quit smoking with Pivot

Pivot has a proven record to help people quit, even if they weren't ready when they joined. It's all about taking the first step. Claim Pivot at no-cost.



Claim Pivot



Download the App



Set Your Goal



Sync Your SmartSensor*



Connect with Your Coach

What happens after I complete the Pivot program?

You must complete at least 6 activities per week for a total of 6 weeks (not consecutive) to satisfy your program goals.

ENGAGEMENT INCLUDES:

- Completing a Pivot lesson or activity
- Engagement in a coaching interaction
- Sampling with CO Sensor
- Posting in Pivot's online community
- Ordering NRT
- Advancing status between Learn, Reduce, Quit, or Maintain
- Setting a Quit Date
- Quit (self-attested or CO validated)



Learn More



Get Started!

Pivot is available at **no cost** to Medical Mutual members ages 18+.

Scan or click the QR code above to visit pivot.co/medmutual to learn more.

**NRT and the Pivot SmartSensor are only available to those who smoke cigarettes.*