MEDICAL MUTUAL®

2017 Individual Underwriting Guidelines

Rev. 9/2017

TABLE OF CONTENTS

NEW BUSINESS – Completing the Application and General Guidelines for Personal Health Insurance 1

A. Applicant and Dependent Eligibility Information 2

B. Effective Date/Open Enrollment 3

C. Effective Date/Special Enrollment 4

D. Prior Deductible/Coinsurance Credit 7

E. Pediatric Dental 7

F. Short Term Plan 8

G. Dental and Vision Only 9

H. Terms and Conditions 9

I. New Business Online Submissions 9

EXISTING BUSINESS – General Procedures and Guidelines 10

A. Medical Plan Benefit Changes 10

B. Adding Dental/Vision Coverage 10

C. Dropping Medical Coverage Only (Keeping Dental and/or Vision) 11

D. Adding Dependents 11

E. Adding Newborns/Adopted Children 12

F. Removing Contract Holder or Dependents 12

G. Removal Due to Divorce 13

H. Dependents Reaching Limiting Age 13

I. Tobacco User Status Update 14

PERSONAL HEALTH PLAN GENERAL POLICIES 15

A. Cancellation Policy 15

B. Refund Premium 15

C. Termination of Contract Holder and/or Dependent 15

D. Reapplication Policy After Cancellation 15

E. Carrier Non-Payment Terminations 16

F. Short Term Cancels (TBD) 16

G. Renewal Policy 16

NEW BUSINESS – Completing the Application and General Guidelines for Personal Health Insurance

A. Applicant and Dependent Eligibility Information

Applicant Eligibility Rules

Applies to: Grandfathered, Transitional/Grandmothered, On-Exchange and Off-Exchange

- The applicant must be a legal resident of, and live in the state of Ohio for at least six months of the year.
- The applicant must not be eligible to elect or purchase Medicare or Medicaid. [Does not apply to vision or dental only contracts.]
- The applicant, if not a U.S. citizen, must be a legally present individual and have a temporary or permanent VISA or green card status.
- The applicant must not reside in the service area only for the intention of obtaining medical care.
- The applicant must meet all Eligibility Standards outlined in 45 CFR 155.305.

Service Areas

Applies to: On-Exchange and Off-Exchange

- In 2017, Medical Mutual offers ACA HMO plans in several areas of Ohio. The following shows the hospital systems with which the HMO plans are affiliated and defines the counties which make up the service area and in which the plan are available. Applicants must maintain primary legal residence in the service area and live there for at least six (6) months of each year.

2017			
Region	**Hospital Network**	**On/Off-Exchange**	**Service Area**
Cincinnati/Springfield	Mercy Hospitals	Off-Exchange On-Exchange	Butler Champaign Clark Clermont Hamilton Mahoning
Lima	Mercy Hospitals	Off-Exchange On-Exchange	Allen Putnam
Toledo	Mercy Hospitals	Off-Exchange On-Exchange	Lucas Wood
Youngstown	Mercy Hospitals	Off-Exchange On-Exchange	Columbiana Mahoning Trumbull
Toledo	ProMedica Hospitals	Off-Exchange On-Exchange	Lucas Wood
Columbus	OhioHealth	On-Exchange	Athens Delaware Fairfield Franklin Hardin Licking Marion Morrow Richland Union

Note:

- HMO Products may be underwritten by Medical Health Insurance Corporation of Ohio (MHICO) or Consumers Life Insurance Company (CLIC) marketed by Medical Mutual.
- Changes will be made to the HMO plan offerings and service areas in 2018. The service areas listed above are only valid for the remainder of 2017.

Eligible Dependents

Applies to: Grandfathered, Transitional/Grandmothered, On-Exchange and Off-Exchange

- Applicant's spouse
- Applicant's common-law spouse [Ohio – must be a common law marriage prior to October 11, 1991 recognized by the state of Ohio supporting documentation must be provided]
- Applicant's same or opposite sex domestic partner are considered eligible when the applicant and domestic partner meet all of the following criteria:
  - cohabit and reside together in the same residence and have done so for at least six months and intend to do so indefinitely;
  - are engaged in an exclusive and committed relationship and are financially interdependent;
  - are both at least 18 years of age and are each other's sole domestic partner;
  - are not married or separated from anyone else;
  - have not had another domestic partner within six months of establishing the current domestic partnership;
  - are not related by blood;
  - are not in this relationship solely for the purpose of obtaining insurance benefits.

  Note: This language is contained in the terms and conditions of the application:
    - Grandfathered and Transitional/Grandmothered: Version X5119 R3/16
    - Off-Exchange: Version X8900 R10/16

- Applicant's, spouse's or domestic partner's (following are eligible categories of dependents):
  - natural children;
  - stepchildren (provided the paternal parent remains married to the applicant and resides in the household);
  - children placed for adoption and legally adopted children;
  - children for whom either the applicant or applicant's spouse/domestic partner is the legal guardian or permanent custodian;
  - children who, by court order, must be provided health care coverage by the applicant or the applicant's spouse/domestic partner.

  Note: Dependents must be under the age of 26 and are subject to all other terms and conditions.

B. Effective Date/Open Enrollment

Open Enrollment Coincides with Renewal Effective Dates

Applies to: Grandfathered and Transitional/Grandmothered

Open Enrollment is the sixty (60) days following the group's renewal effective date. Requests (such as adding dependents and benefit changes) must be submitted within this Open Enrollment period in order to be processed without a qualifying event and supporting documentation. A qualifying event with a special enrollment period and supporting documentation are required if requests are submitted outside the Open Enrollment period.

2018 Open Enrollment Begins on November 1, 2017 and runs through December 15, 2017

Applies to: Off-Exchange

The effective date for the Open Enrollment will be January 1, 2018. Applications must be submitted by December 15, 2017 in order to be approved for coverage in 2018. In order to effectuate the policy, binder (first month's premium) payments must be submitted within 30 days of the application submission date or by the effective date, whichever is later. [Open Enrollment dates are subject to change at the discretion of the Federal Government. Medical Mutual will adhere to all requirements as they apply.]

- ***Example 1:*** A binder payment needs to be submitted by December 31, 2017 for an application submitted on November 1, 2017 to effectuate the policy January 1, 2018.
- ***Example 2:*** A binder payment needs to be submitted by January 15, 2018 for an application submitted on December 15, 2018 to effectuate the policy January 1, 2018.

2018 Open Enrollment Begins on November 1, 2017 and runs through December 15, 2017
Applies to: On-Exchange

The effective date for the Open Enrollment will be January 1, 2018. A licensed agent may enroll clients directly through mybrokerlink.com using their FFM log in and password. Applications must be submitted by December 15, 2017 in order to be approved for coverage in 2018. In order to effectuate the policy, binder (first month's premium) payments must be submitted within 30 days of the application submission date or by the effective date, whichever is later. [Open Enrollment dates are subject to change at the discretion of the Federal Government. Medical Mutual will adhere to all requirements as they apply.]

- ***Example 1:*** A binder payment needs to be submitted by December 31, 2017 for an application submitted on November 1, 2017 to effectuate the policy January 1, 2018.
- ***Example 2:*** A binder payment needs to be submitted by January 15, 2018 for an application submitted on December 15, 2018 to effectuate the policy January 1, 2018.

C. Effective Date/Special Enrollment

Applies to: Grandfathered, Transitional/Grandmothered, On-Exchange and Off-Exchange

Note: On-Exchange enrollment and eligibility rules are handled and verified primarily by the Federally Facilitated Marketplace (FFM). In some situations, Medical Mutual may be given latitude to apply the Medical Mutual On-Exchange guidelines included here.

A special enrollment may be applicable for applicants who have a qualifying event as defined below and in the "Special Enrollment" section of the application. Special enrollment must take place within 60 days of the qualifying event. Applications received outside the eligible time limit of the qualifying event will not be accepted. The applicant may reapply during the next open enrollment period. If there is no special enrollment, the applicant may need to wait until next open enrollment period to enroll (see "Effective Date/Open Enrollment" section above).

Event	Qualifying Event Date	Required Documentation
Termination of employment[2]	Date eligibility for existing Minimum Essential Coverage is lost	Letter from employer on company stationery and signed by company officer, or completion of "Loss of Employer-Sponsored Coverage Form". Letter must state employee's/covered dependent(s)'name(s), verify date coverage was terminated and specify the reason for termination.
Reduction in hours worked[2]	Date eligibility for existing Minimum Essential Coverage is lost	Letter from employer on company stationery and signed by company officer, or completion of "Loss of Employer-Sponsored Coverage Form". Letter must state employee's/covered dependent(s)'name(s), and verify date of reduction in hours.
Divorce or legal separation[2,9]	Date eligibility for existing Minimum Essential Coverage is lost	One of the following may be used: • Letter from employer/carrier on company stationery and signed by company officer. Letter must verify date coverage was terminated and caused by loss of eligible dependent status. • Copy of filed and stamped divorce decree along with proof verifying date prior coverage was terminated.
Death of spouse/parent[2,9]	Date eligibility for existing Minimum Essential Coverage is lost	Letter from employer/carrier on company stationery and signed by company officer. Letter must verify date coverage was terminated and caused by loss of eligible dependent status.
Dependent reaching limiting age[2]	Date eligibility for existing Minimum Essential Coverage is lost	Letter from employer/carrier on company stationery and signed by company officer. Letter must verify date coverage was terminated and caused by loss of eligible dependent status.

Event	Qualifying Event Date	Required Documentation
No longer qualify for Medicaid or Children's Health Insurance Program (CHIP)[2]	Date eligibility for existing Minimum Essential Coverage is lost	Termination of coverage letter for Medicaid or CHIP. Letter must include termination date.
Expiration of COBRA benefits[2]	Date eligibility for existing Minimum Essential Coverage is lost	Documentation of COBRA expiration. Letter must include termination date.
Marriage[1,2,6,8]	Date of marriage	Marriage certificate signed by the officiant and proof of at least 1 day of minimum essential coverage within the last 60 days for at least one spouse.
Birth[3,7,8]	Date of birth	None (date of birth should be entered on application)
Adoption[3,8]	Date of adoption	Adoption papers/legal guardianship papers
Placement for adoption[3,8]	Date of placement	Adoption papers/legal guardianship papers
Placement into foster home[3,8]	Date of placement	Legal guardianship papers
Child support or other court order[3,8]	Date order is issued	Copy of child support or other court order, which displays date order was issued and names of parties involved.
I moved to Ohio [1,4,10]	Date of permanent move	Proof of at least 1 day of minimum essential coverage within the last 60 days and one of the following items for both your prior and new address: • Utility bill • Lease agreement • Mortgage Paperwork • Letter from employer if move based on employment
I moved within the State of Ohio.[1,4,9,10] **Note:** If a member moves into an area whereby they are now offered new products that were not available to them before, then they do qualify for the move special enrollment and they can purchase any product. If a member moves into an area whereby the same exact products are available to them as their previous address, then they do not qualify for the move special enrollment.	Date of permanent move	Proof of at least 1 day of minimum essential coverage within the last 60 days and one of the following items for both your prior and new address: • Utility Bill • Lease Agreement • Mortgage paperwork • Letter from employer if move based on employment
Newly ineligible for federal subsidy[4]	Date notified of new eligibility status	Newly ineligible for subsidy, the individual may apply in the off-exchange market. Medical Mutual will require termination of subsidy document, which must include the date the subsidy will terminate.
Existing individual policy being terminated[2,5] (not including termination in cases of rescission or non-payment)	Date policy will be terminated	Copy of termination letter, which displays date of termination.
Existing individual non-calendar year (1/1 effective date) renewal[2]	Date renewal is effective	Copy of renewal, which displays renewal effective date.

Event	Qualifying Event Date	Required Documentation
Employer ceases to offer employer sponsored group health coverage including the employer terminating employer contributions[2]	Date eligibility for existing Minimum Essential Coverage is lost	Letter from employer on company stationery and signed by company officer, or completion of "Loss of Employer-Sponsored Coverage Form". Letter must state employee's/covered dependent(s)'name(s), and verify date coverage was terminated.

Additional Notes:

Applications without a qualifying special enrollment event are not eligible for coverage outside the annual open enrollment period. For many events, coverage will not be effectuated on the date of the event in accordance with individual marketplace rules. All ACA Individual policies must renew effective January 1.

[1]**Minimum Essential Coverage:** As defined by healthcare.gov, this is the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Dependent Limiting Age: To be considered eligible dependents, children's ages must fall within the age limit specified in the certificate of coverage. When a child reaches the limiting age for their current plan and is terminated from their existing coverage, this may cause a special enrollment event.

- Grandfathered and Transitional/Grandmothered: Dependents age 26 or 27 on the policyholder's 2016 renewal may remain on the policy until they turn 28. They will be removed from the policy at the end of the month during which they turn age 28. Dependents under age 26 on the policyholder's 2016 renewal will be removed from the policy at the end of the month during which they turn age 26. When aging off a parent's policy, a dependent may enroll in any ACA plan for which they qualify.
- On-Exchange and Off-Exchange: The limiting age is 26.

Time Limit: The applicant must follow these time limits to apply for coverage or make a change:

- Grandfathered and Transitional/Grandmothered: 31 days from the qualifying event date
- On-Exchange and Off-Exchange: 60 days from the qualifying event date

Effective Dates:

[2]Coverage will become effective on the first day of the following month after complete enrollment materials (including event documentation) are received.

[3]Coverage will become effective on the date of birth, adoption, placement for adoption or placement into a foster home.

[4]If complete enrollment materials (including event documentation) received between:

- 1st and 15th day of month, coverage effective on 1st day of the following month.
- 16th and last day of the month, coverage effective on 1st day of the second following month.

Note:

- The date ALL required materials are received by Medical Mutual will be considered the submission date to determine eligibility and effective date.
- Final effective dates for On-Exchange policies are determined by the Federally Facilitated Marketplace (FFM).

Enrollment Notes:

[5]Voluntary termination of an existing individual policy not in connection with a renewal does not create a special enrollment event.

[6]**Marriage**: This qualifying event allows individuals to enroll in coverage. When required, proof of at least 1 day of minimum essential coverage within the last 60 days must be supplied, even in those instances when the member had prior coverage with another carrier, unless they were previously living in a foreign country or U.S. territory or are AIAN (Shareholders in Alaska Native Corporations).

[7]**Birth**: This qualifying event allows individuals to enroll in coverage even if they do not currently have coverage.

A special enrollment period (SEP) is opened due to the birth of a baby to allow for a spouse or other dependents to be added. However, a domestic partner (and a domestic partner's child(ren)) are not eligible for this special enrollment and can only be added at open enrollment. The newborn must also be listed on the application and be covered under the policy.

Metal Level
Applies to: On-Exchange and Off-Exchange

[8]For the special enrollment for gaining or becoming a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support or other court order enrollees may only add new dependents to:

- The existing plan, or
- On-Exchange: A separate plan at the same metal level if they cannot be added to the existing plan
  Off-Exchange: A separate plan at the same or a lower metal level if they cannot be added to the existing plan

Note: The special enrollment for members of federally recognized tribes and Shareholders in Alaska Native Corporations (AIAN), Errors of the Exchange, Exceptional Circumstances, and Victims of domestic abuse and spousal abandonment are exempt from this requirement.

[9]For most other special enrollments, plan changes may be made to:
On-Exchange: A plan in the same metal level
Off-Exchange: A plan in the same or lower metal level

Note: This requirement does not apply to dependents that receive a special enrollment due to reaching limiting age or to enrollees coming from another carrier and/or group coverage. The special enrollment for members of federally recognized tribes and Shareholders in Alaska Native Corporations (AIAN), Errors of the Exchange, Exceptional Circumstances, and Victims of domestic abuse and spousal abandonment are exempt from this requirement.

[10]**Moving within or to the State of Ohio**: For the special enrollments of moving within or to the State of Ohio, proof of at least 1 day of minimum essential coverage within the last 60 days must be supplied, even in those instances when the member had prior coverage with another carrier, unless they were previously living in a foreign country or U.S. territory or are AIAN (Shareholders in Alaska Native Corporations).

D. Prior Deductible/Coinsurance Credit

Applies to: Grandfathered, Transitional/Grandmothered, On-Exchange and Off-Exchange

Medical Mutual does not allow credit for any deductible or coinsurance met under a previous carrier's individual or group health plans.

E. Pediatric Dental

Applies to: Off-Exchange

The PPACA requires that ALL individuals carry pediatric dental benefits. Therefore, this coverage must be included unless an applicant can provide proof of existing pediatric dental benefits through another carrier. Such proof must be included with application to Medical Mutual. If proof is not received, pediatric dental benefits and the corresponding premiums will be automatically added retroactive to the original effective date.

Proof of Pediatric Dental Coverage (complete ALL):

- Complete dental waiver portion of the employee application
- Supply a copy of the ID card or a copy of the current billing statement from the dental insurance company showing the policyholders' name and the name of the insurance company.
- Proof should be submitted to PediatricDentalWaiver@medmutual.com at the same time application is submitted. If Medical Mutual does not receive proof of other pediatric dental coverage within 30 days of the effective date, pediatric dental coverage will be added to the policy retroactive to the effective date at the standard rate for this coverage.

Notes:

- Pediatric dental coverage will be removed for a dependent at the end of the month during which they turn age 19.

- This coverage is only available in the Medical Mutual Off-Exchange. Pediatric dental coverage is not offered by Medical Mutual On-Exchange.
- If another Medical Mutual dental option is elected (subject to availability), a waiver for pediatric dental coverage does not need to be completed. These plans automatically satisfy the pediatric dental coverage requirement.

F. Short Term Plan

Applies to: Short Term

Medical Eligibility

Medical underwriting is the function used to assess the insurability of an applicant and his/her dependents when enrolling in a short term health insurance product. The medical underwriting process provides verification of the individual's medical claims history and provides an adequate assessment of the applicant's health conditions. The Medical Mutual underwriting department uses the medical information obtained to determine whether the prospective applicant is an acceptable risk. Therefore, if an applicant has selected a health plan, he/she must complete this section of the application for himself/herself and each dependent listed on the application.

The applicant must indicate either "yes" or "no" to each condition or question for each person listed on the application. Any condition or question that is marked "yes" must be explained clearly in the space provided. Use a separate sheet of paper if there is not enough space on the application. The applicant must provide complete details of any treatment(s) that he/she or any listed dependent(s) received, including:

- Patient name
- The specific name/diagnosis of the condition, the type of treatment received, and the start date and the end date of the treatment
- If medication was prescribed, provide the name of the medication, dosage and frequency
- The complete name and address of the doctor, clinic, or hospital that treated the applicant/ dependent

Rating Guidelines

The following are rating guidelines used in evaluating applications:

- Applicants/dependents are considered a tobacco user if they meet the following definition: the legal use (other than religious or ceremonial) of any tobacco product on average four or more times per week within no longer than the last six months.
- Applicants/dependents with undiagnosed symptoms may be declined coverage until a specific diagnosis is made.
- Applicants/dependents contemplating (or who have been advised to have) surgery may be declined until the surgery is completed and the applicant/dependent fully recovers.
- Applicants/dependents currently receiving treatment for a non-chronic condition such as a broken bone or physical therapy may be declined until their doctor gives him/her a clean bill of health.
- An applicant's/dependent's build (height/ weight ratio) may render him/her medically ineligible for individual plans.
- Applicants/dependents that have multiple insurable conditions may be declined based on the combination of those conditions or along with other factors such as age, height, weight, and smoking status.
- All conditions must be included in the rating evaluation. Deviations from standard underwriting practices must be approved by the Medical Mutual Underwriting Department.

Note: Please be sure that all required portions of the applications are complete prior to submitting in order to prevent any delay in processing.

Attending Physician's Statement

Underwriting may request an attending physician's statement (APS) to supplement information disclosed on the application. Underwriting may request an APS if the application indicates a condition that requires more detailed information.

Note: Medical Mutual will not cover any fees assessed by any physician requested to provide information or for a physician examination. All such expenses are the responsibility of the applicant.

Application Declined

If Medical Mutual medically declines an applicant for a Short Term Health Plan the applicant may reapply and must include the appropriate medical documentation, i.e. attending physician's statement, medical records, etc. The applicant must wait at least

six months before reapplying. If the case is resubmitted after the six-month period, after a medical decline, then the applicant must also submit appropriate medical documentation, i.e. attending physician's statement, medical records, etc.

Length of Short Term Policy

Effective 4/1/17 short term policies will be three months (not 90 days). A maximum of four consecutive polices will be allowed.

- Example 1 - Prior to 4/1/17: Member was able to enroll in two consecutive 180 day policies (total 360 days);
- Example 2 - Prior to 4/1/17: Member purchased a 180 day short term (ending 8/17), and could be approved for two more (three month) short term policies (approximately 360 days);
- Example 3 - After 4/1/17: Member is able to enroll in up to four consecutive three month policies (approximately 360 days)

Note: It is possible that a person could get more than 360 days' worth of coverage because some months are longer than 30 days.

Short Term Policies Effective Dates 4/1/2017 and After (3 Month Policies)		
Effective Date of ST Policy	**Dates of Service (DOS) Covered**	**Dates of Service (DOS) Not Covered**
5/5	(DOS) 5/5 through & including 8/4	5/4 and any other dates (DOS) prior to 5/5 8/5 and any other dates 8/5 and after
1/2	(DOS) 1/2 through & including 4/1	1/1 and any other dates (DOS) prior to 1/2 4/2 and any other dates 4/2 and after

G. Dental and Vision Only

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Applicants may apply for dental and/or vision only plans with Medical Mutual at any time during the year. The effective date for dental and/or vision plans will be the first of the month following receipt of all required documents. Premium may be collected on an annual basis for dental and/or vision only policies. All Off-Exchange dental and vision policies will renew January 1.

Dental and/or vision only policies that were in existence prior to 2014 are on an annual billing cycle and may only be cancelled on the anniversary date. ***For example***, a dental only policy that was sold on 7/1/2012 only be cancelled 7/1 of any given year.

Dental and/or vision only policies effective on or after 1/1/2014 are on a monthly billing cycle. ***For example***, if Medical Mutual receives the cancellation request on 9/4, the cancellation would be effective 10/1.

H. Terms and Conditions

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

The applicant, spouse/domestic partner, or any dependent 18 years or older, if eligible and applying, must read the terms and conditions, then sign and date the application. All applications are considered invalid 60 days after the signature date.

I. New Business Online Submissions

Applies to: On-Exchange, Off-Exchange and Short Term

On-Exchange

Licensed agents may enroll clients directly through mybrokerlink.com using their FFM log in and password.

Off-Exchange

New business being submitted for Off-Exchange products must be submitted through Medical Mutual's online Health Insurance Marketplace which can be accessed through MyBrokerLink. Please consult your Medical Mutual individual Sales Representative for information on this enrollment tool.

Short Term

New business being submitted for Short Term products should be submitted through Medical Mutual's Online App which can be accessed through MyBrokerLink. Please consult your Medical Mutual individual Sales Representative for information on this enrollment tool.

EXISTING BUSINESS – General Procedures and Guidelines

A. Medical Plan Benefit Changes

Applies to: Grandfathered, Transitional/Grandmothered, On-Exchange and Off-Exchange

Grandfathered and Transitional/Grandmothered

In order to remain Grandfathered or Transitional/Grandmothered, these policies must remain on their current medical and prescription plans. Any plan change will require the member to reapply into an ACA-compliant health plan.

Off-Exchange

If a subscriber wishes to request a benefit downgrade or upgrade, Medical Mutual must receive a written request from the contract holder identifying the new product (subject to availability).

All ACA Off-Exchange individual policies will renew January 1, 2018. Benefit change requests must be received by Medical Mutual between November 1, 2017 and December 15, 2017. ***For example,*** if a policy's renewal date is January 1, changes received no later than December 15th will be processed effective January 1, and anything received outside this window will be considered off-cycle. Medical plans may not be changed off-cycle. [Open Enrollment dates are subject to change at the discretion of the Federal Government. Medical Mutual will adhere to all requirements as they apply.]

On-Exchange

Contact the Federally Facilitated Marketplace (FFM) in order to make any changes to the policy.

Submission: All requests should be submitted:

- During Open Enrollment Only for Off-Exchange Only: Electronically using Individual Member Maintenance accessible via MyBrokerLink and MyHealthPlan, or
- To ChangeRequests@medmutual.com, clearly stating the group number, member(s) name(s), member(s) ID(s), requested effective date (see above rules for effective dates), and the medical plan option in which the member(s) would like to enroll.

B. Adding Dental/Vision Coverage

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Grandfathered and Transitional/Grandmothered

Existing members with medical coverage may be eligible to add an available dental or vision plan anytime during their contract. The effective date will be the first of the month following receipt of request to add dental or vision coverage.

Off-Exchange

Existing members with medical coverage may be eligible to add an available dental or vision plan anytime during their contract. The effective date will be the first of the month following receipt of request to add dental or vision coverage. All Off-Exchange dental/vision policies will renew January 1.

On-Exchange

Contact the Federally Facilitated Marketplace (FFM) in order to make any changes to the policy.

Submission: All requests should be submitted:

- During Open Enrollment Only for Off-Exchange Only: Electronically using Individual Member Maintenance accessible via MyBrokerLink and MyHealthPlan, or
- To ChangeRequests@medmutual.com, clearly stating the group number, member(s) name(s), member(s) ID(s), requested effective date (see above rules for effective dates), and the dental and/or vision plan option the member(s) would like to add.

Note: Dental and/or vision coverage will only be added on a go-forward basis in these situations.

C. Dropping Medical Coverage Only (Keeping Dental and/or Vision)

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Grandfathered, Transitional/Grandmothered and Off-Exchange

Policies with medical, dental and/or vision coverage may cancel the medical portion for all members on the policy. Dental and/or vision only coverage will remain under the existing group number. Split contracts (contracts where some but not all members are enrolled in a plan) are not permissible.

On-Exchange

On-exchange policies are medical only and are not combined with dental/vision. Therefore, this does not apply to On-Exchange policies.

Submission: All requests should be submitted:

- During Open Enrollment Only for Off-Exchange Only: Electronically using Individual Member Maintenance accessible via MyBrokerLink and MyHealthPlan, or
- To ChangeRequests@medmutual.com, clearly stating the group number, member(s) name(s), member(s) ID(s), requested effective date (see above rules for effective dates), the plans that the policy would like to drop and maintain.

Note: Medical coverage will only be removed on a go-forward basis in these situations.

D. Adding Dependents

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Grandfathered and Transitional/Grandmothered

New dependents may be added to the policy as a result of a qualifying event (refer to "Special Enrollment" section of the application or the "Effective Date/Special Enrollment" section of this guide) or at renewal. A spouse and/or dependent that becomes eligible for coverage must submit a newly completed application and medical history questionnaire. **The application must be received within 31 days of the qualifying event or renewal date and will be medically underwritten. Existing rates may be adjusted based on the medical history of the additions to the contract, and in some circumstances coverage may be declined.** The effective date of additions to contracts will be the first of the month following receipt of complete enrollment materials by Medical Mutual.

Off-Exchange

Refer to "Special Enrollment" section of the application or the "Effective Date/Special Enrollment" section of this guide for a list of qualifying events and the corresponding effective dates. If there is not a qualifying event, dependents may be added at the time of renewal/open enrollment for a January 1st effective date.

On-Exchange

Contact the Federally Facilitated Marketplace (FFM) in order to make any changes to the policy.

Submission: All requests should be submitted:

- During Open Enrollment Only for Off-Exchange Only: Electronically using Individual Member Maintenance accessible via MyBrokerLink and MyHealthPlan, or
- To ChangeRequests@medmutual.com, clearly stating the group number, requested effective date and newly completed individual applications (located on MyBrokerLink):
  - Grandfathered and Transitional/Grandmothered: completed application/medical health questionnaire X5119 R3/16
  - Off-Exchange: completed application X8900 R10/16

E. Adding Newborns/Adopted Children

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Grandfathered and Transitional/Grandmothered

A newborn or an adopted child will be covered for 31 days from birth or adoptive placement in the home and will not be subject to insurability requirements. An application must be submitted to Medical Mutual within 31 days of birth or adoption in order to continue coverage beyond 31 days.

Note: When a dependent is added to a policy, the current premium may change and the policy may be re-underwritten.

Off-Exchange

A newborn or an adopted child will be covered for 31 days from birth or adoptive placement in the home and will not be subject to insurability requirements. An application must be submitted to Medical Mutual within 60 days of birth or adoption in order to continue coverage beyond 31 days.

Note: When a dependent is added to a policy, the current premium may change.

On-Exchange

Contact the Federally Facilitated Marketplace (FFM) in order to make any changes to the policy.

Submission: All requests should be submitted:

- During Open Enrollment Only for Off-Exchange Only: Electronically using Individual Member Maintenance accessible via MyBrokerLink and MyHealthPlan, or
- To ChangeRequests@medmutual.com, clearly stating the group number, requested effective date and newly completed individual applications (located on MyBrokerLink):
  - Grandfathered and Transitional/Grandmothered: completed application/medical health questionnaire X5119 R3/16
  - Off-Exchange: completed application X8900 R10/16

F. Removing Contract Holder or Dependents

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Grandfathered and Transitional/Grandmothered

If a contract holder, spouse or dependent drops coverage, Medical Mutual reserves the right to medically underwrite those that remain active on the policy. Rerating is based on the medical claims history of the policy. The rates will not change for those remaining on the policy if:

- The contract holder or spouse leaves due to Medicare
- The contract holder or spouse leaves due to divorce (see section "Removal Due to Divorce" for more details)
- The contract holder, spouse or dependent is removed due to death

Note: When a contract holder is removed from a policy, the spouse or dependent(s) may be "switched" to the contract holder. A new group number will be assigned. Grandfathered status is not impacted by this change.

- Example 1: Mr. and Mrs. Smith enroll on plan with Mr. Smith as the policyholder. Mr. Smith turns 65 and becomes Medicare-eligible and requests cancellation from the plan. Mrs. Smith may take over the contract holder position.
- Example 2: Mr. Smith and a dependent child are enrolled on a plan with Mr. Smith as the policyholder. Mr. Smith turns 65 and becomes Medicare-eligible and requests cancellation from the plan. The dependent child may take over the contract holder position. (**Multiple children:** Children are not eligible dependents of each other. Therefore, separate child only policies would be required with separate identification cards.)

Off-Exchange

When a contract holder is removed from a policy, an existing member on the policy may be "switched" to the contract holder.

Note: In both of the below situations, a new group number will be assigned.

- Example 1: Mr. and Mrs. Smith enroll on plan with Mr. Smith as the policyholder. Mr. Smith turns 65 and becomes Medicare-eligible and requests cancellation from the plan. Mrs. Smith may take over the contract holder position.
- Example 2: Mr. Smith and a dependent child are enrolled on a plan with Mr. Smith as the policyholder. Mr. Smith turns 65 and becomes Medicare-eligible and requests cancellation from the plan. The dependent child may take over the contract

holder position. (**Multiple children:** Children are not eligible dependents of each other. Therefore, separate child only policies would be required with separate identification cards.)

On-Exchange
Contact the Federally Facilitated Marketplace (FFM) in order to make any changes to the policy.

Note: When there is a switch in policyholder, membership will submit forms to have the deductible transferred to the new policy.

Submission: All requests should be submitted:
- During Open Enrollment Only for Off-Exchange Only: Electronically using Individual Member Maintenance accessible via MyBrokerLink and MyHealthPlan, or
- To ChangeRequests@medmutual.com, clearly stating the group number and requested effective date

G. Removal Due to Divorce

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Grandfathered and Transitional/Grandmothered
When a contract holder or spouse leaves the policy due to divorce, they may obtain their own coverage for the same plan at the same rate under their own group number. A request must be completed to remove them from the existing policy and they must also complete the 1st page, signature page and billing page of the application with their updated information along with a copy of the finalized divorce decree. These individuals may also be able to apply for a new ACA plan, within 60 days, on- or Off-Exchange. Applying for a new ACA plan will require submission through the Federally Facilitated Marketplace (FFM) or Medical Mutual's online enrollment tool for the Medical Mutual Off-Exchange product.

Off-Exchange
Please see the "Effective Date/Special Enrollment" section of this guide for a list of qualifying events and the corresponding effective dates.

On-Exchange
Contact the Federally Facilitated Marketplace (FFM) in order to make any changes to the policy.

Note: When there is a switch in policyholder, membership will submit forms to have the deductible transferred to the new policy.

Submission: All requests should be submitted:
- During Open Enrollment Only for Off-Exchange Only: Electronically using Individual Member Maintenance accessible via MyBrokerLink and MyHealthPlan, or
- To ChangeRequests@medmutual.com, clearly stating the group number and requested effective date and including newly completed individual applications (located on MyBrokerLink):
  - Grandfathered and Transitional/Grandmothered: completed application/medical health questionnaire X5119 R3/16
  - Off-Exchange: completed application X8900 R10/16

H. Dependents Reaching Limiting Age

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Dependents reaching limiting age will be automatically removed by Medical Mutual membership. Please see the "Effective Date/Special Enrollment" section of this guide for a list of qualifying events and the corresponding effective dates.

Grandfathered and Transitional/Grandmothered
Effective January 1, 2016, Ohio law lowered the limiting age for dependent children from 28 to 26. This change applied to plans upon first renewal occurring on or after January 1, 2016. Dependents age 26 or 27 on the policyholder's 2016 renewal may remain on the policy until they turn 28. They will be removed from the policy at the end of the month during which they turn age 28. Dependents under age 26 on the policyholder's 2016 renewal will be removed from the policy at the end of the month during which they turn age 26.

Off-Exchange

Effective January 1, 2016, Ohio law lowered the limiting age for dependent children from 28 to 26. This change applied to all Off-Exchange plans on January 1, 2016. Medical Mutual will remove the dependents that age out at the end of each month (dependents turning 26 after 1/1 renew date). It is up to the dependent to purchase a new plan and to do so within the time limit for this special enrollment qualifying event.

On-Exchange

For policies purchased through the Federally Facilitated Marketplace (FFM), please refer to their guidelines. Medical Mutual will not manually remove the dependents that age out of eligibility. Medical Mutual will make updates as they are received from the Federally Facilitated Marketplace (FFM).

Note:

- Anytime a member is moved to a new group number all deductibles and accumulations will start over. Dependents reaching limiting age will be removed by membership upon the end of the month.

Submission: To apply for new ACA coverage with Medical Mutual, an application must be submitted within 60 days of the qualifying event and will follow effective date rules outlined in the "Special Enrollment" section of the application or the "Effective Date/Special Enrollment" section of this guide.

I. Tobacco User Status Update

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Definition of tobacco user (as appears on our application): the legal use (other than religious or ceremonial) of any tobacco product on average four or more times per week within no longer than the last six months.

Note: Effective 7/14/2017, the following now fall under the definition of "tobacco use": e-cigarettes, e-hookah, vape pens, advanced refillable personal vaporizers, and electronic pipes.

Grandfathered, Transitional/Grandmothered and Off-Exchange

If the member no longer meets the definition of tobacco user, the member may notify us at any time and the tobacco user status will be adjusted within the membership system. Rates will not change until next renewal at which time the member will renew into the updated tobacco user status.

On-Exchange

Contact the Federally Facilitated Marketplace (FFM) in order to make any changes to the policy.

Submission: All requests should be submitted:

- During Open Enrollment Only for Off-Exchange Only: Electronically using Individual Member Maintenance accessible via MyBrokerLink and MyHealthPlan, or
- To IndividualPolicyRecert@medmutual.com, identifying the submission as a tobacco user status update, clearly stating the group number, member's name, member ID, tobacco quit date, and including newly completed individual applications (located on MyBrokerLink):
  - Grandfathered and Transitional/Grandmothered: completed application/medical health questionnaire X5119 R3/16
  - Off-Exchange: completed application X8900 R10/16

Note: If the member believes their tobacco user status is incorrect please send an inquiry with member's name, group number and ID number to ChangeRequests@medmutual.com. Underwriting will review the case to verify the documentation we have in history.

PERSONAL HEALTH PLAN GENERAL POLICIES

A. Cancellation Policy

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Medical Coverage

To cancel coverage, a subscriber must notify Medical Mutual in writing 31 days prior to the desired cancellation date. Medical Mutual will cancel the policy on the specified date if premiums are paid to that date and Medical Mutual received the notice prior to that date. If a subscriber does not specify a cancellation date, Medical Mutual will cancel the policy on the first of the month following receipt of the notice or the premium paid to date. Underwriting may review exception requests for retroactive cancellation; cancellations will not be approved more than 31 days retroactive or if there are claims on our system within the last 31 days, cancellation will only be considered for the day after the last claim. Cancellation request submissions must include the member's name, group number and member ID number.

The subscriber may email, fax or mail his/her written cancellation notice to Medical Mutual to:

Email: memapps@medmutual.com
Fax: 216-687-6352 (fax)
Mail: Medical Mutual
MZ: 01-6B-6200
2060 East Ninth Street
Cleveland, Ohio 44115

Cancellation requests being submitted by an agent may be sent to SM1membership@medmutual.com.
Exception requests may be submitted by the broker with documentation to ChangeRequests@medmutual.com.

Note: If your policy was purchased through the Federally Facilitated Marketplace (FFM), you must contact them for instructions on how this process will work.

B. Refund Premium

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Medical Coverage

Medical Mutual will refund any prepaid premiums only if thirty (30) day written notice of policy cancellation is submitted to Medical Mutual prior to the cancellation date.

C. Termination of Contract Holder and/or Dependent

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

A subscriber's and or dependent's coverage will terminate automatically when:

- The policy terminates.
- The contract holder/dependent ceases to be eligible for coverage under the terms and conditions of the policy.
- The required premiums are not paid within the 31-day grace period. Medical Mutual will cancel delinquent policies retroactively to the last premium paid to date.

Note: If your policy was purchased through the Federally Facilitated Marketplace (FFM), you must contact them for instructions on how this process will work.

D. Reapplication Policy After Cancellation

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

Please see the Effective Date/Open Enrollment or Effective Date/Special Enrollment section under New Business of this guide for a list of qualifying events and the corresponding effective dates.

Note: If your policy was purchased through the Federally Facilitated Marketplace (FFM), you must contact them for instructions on how this process will work.

E. Carrier Non-Payment Terminations

Applies to: Grandfathered, Transitional/Grandmothered and Off-Exchange

If Medical Mutual terminates a policy for non-payment of premium, then the subscriber may apply for reinstatement within 60 days of the date of cancellation. The subscriber must make a written request detailing the reasons for the delinquency. Subscribers may fax or mail written requests to:

Email: Reinstatement@medmutual.com
Fax: 216-687-1579 (fax)
Mail: Medical Mutual
Collections Department/MZ: 01-7B-5315
2060 East Ninth Street
Cleveland, Ohio 44115

For more details, please refer to the member's certificate.

F. Short Term Cancels (TBD)

Applies to: Short Term

If a subscriber terminates their short-term policy prior to the 3 month end date, then he/she must wait at least 6 months to reapply for another short-term policy. Members are permitted to have 4 consecutive short term policies. After the 4th consecutive policy, they must wait at least 90 days to reapply. A 5th consecutive short term policy will not be considered.

Note: All applications are subject to medical underwriting and must be submitted to MMIndividual@medmutual.com or online via MedMutual.com

G. Renewal Policy

Applies to: Grandfathered, Transitional/Grandmothered, On-Exchange and Off-Exchange

Medical Mutual will release renewal notification to the policyholder as timely as possible.

Note: All ACA plans will renew January 1 (this includes any new ACA plan policy regardless of effective date).